A REVIEW OF THE ADMINISTRATION FY2004 HEALTH CARE PRIORITIES

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BEFORE THE

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A REVIEW OF THE ADMINISTRATION FY2004 HEALTH CARE PRIORITIES

WEDNESDAY, FEBRUARY 12, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., in room 2123, Rayburn House Office Building, Hon. W.J. "Billy" Tauzin (chairman) presiding.

Members present: Representatives Tauzin, Bilirakis, Barton, Upton, Stearns, Gillmor, Greenwood, Cox, Deal, Burr, Whitfield, Norwood, Shimkus, Wilson, Shadegg, Fossella, Buyer, Radanovich, Bass, Bono, Walden, Terry, Fletcher, Rogers, Issa, Otter, Waxman, Markey, Towns, Pallone, Brown, Deutsch, Eshoo, Stupak, Engel, Wynn, Green, McCarthy, Strickland, DeGette, Capps, John, Davis, Allen, Schakowsky, and Solis.

Staff present: Kathleen Weldon, majority professional staff; Patrick Morrisey, deputy staff director; Eugenia Edwards, legislative clerk; John Ford, minority counsel; Bridgett Taylor, minority professional staff; Karen Folk, minority professional staff; Amy Hall, minority professional staff; and Jessica McNiece, minority staff assistant.

Chairman TAUZIN. The committee will please come to order.

Before the Chair recognizes himself for an opening statement, I have a brief unanimous consent request. As members may recall, there was a lengthy discussion about opening statements at our committee organization meeting 2 weeks ago, and the ranking member and I discussed a possible committee rule change to address what is often very lengthy periods for opening statements.

The following request is modeled after our discussion. I ask unanimous consent that during the period for opening statements, and prior to the recognition of our first witness for testimony, any member, when recognized, may completely defer his or her 3-minute opening statement and instead use those 3 minutes during the initial round of witness questioning.

By way of explanation, a couple of points. If a member comes after all opening statements have been completed, he or she will just be entitled to the usual 5 minutes of questioning.

And, two, members may not defer a portion of their statement, members may only defer their statement completely, that means all 3 minutes, or not at all. That is, they can deliver a 1-minute opening statement, but if they do they cannot reserve the remaining 2 minutes. You either reserve all three or none at all.

Finally, members desiring to defer their 3 minutes must be here to be recognized for that purpose.

Is there any objection to that request?

Mr. WAXMAN. Reserving the right to object——

Chairman TAUZIN. Mr. Waxman?

Mr. WAXMAN. [continuing] and I won't object, Mr. Chairman, but if we are going to follow this rule, then some members will get additional time to pursue questions. I understand the Secretary's time is limited, but I hope he will stay, so that all members will have a chance to ask him questions, because it would be a shame if this rule gave some members reward of extra time to pursue questions, but then not all members would be able to get their chance.

Chairman TAUZIN. My understanding is that the Secretary has 2½ hours for us today, and I think that will accommodate us all. But by the way, you will get your 3 minutes either way, an opening statement or in questions. So it gets used up one way or the other.

Is there any objection to the unanimous consent request? Hearing none, it is so ordered, then. And the Chair will recognize himself for an opening statement.

Our committee is, once again, very fortunate to have Secretary Tommy Thompson testify before us today. The Secretary has done an outstanding job for this administration in some extraordinary times, and for that he should be commended. Like the administration, the Energy and Commerce Committee has a very ambitious health care agenda on tap for the next several months.

We will be addressing a significant number of issues, including Medicare modernization, Medicaid reform, medical liability reform, global AIDS, bioshields, substance abuse treatment, patient safety, the uninsured, and the important vaccine-related matters to name just a few.

Under the President's proposed budget, the Department of Health and Human Services will have outlays of $539 billion in the year 2004. That is an increase of 7.3 percent over the President's proposed 2003 levels. The discretionary component of the budget is proposed at $65 billion. That is an increase of 2.6 percent.

The budget continues the President's commitment to strengthen and modernize our entitlement programs, to fight bioterrorism—an increasingly difficult subject—and to increase biomedical research, and expanding Americans' access to health care services.

The President has proposed some innovative new initiatives that we need to examine closely here in our committee, and that is why it is particularly timely to have the Secretary with us. Mr. Secretary, we would like to discuss your bold new option for States under the Medicaid program.

Under this proposal, States would be able to take their Federal Medicaid funding in two lump-sum allotments, one for long-term care services and one for acute care services. The budget includes $3.4 billion in additional Medicaid funds for 2004 for States that elect this option, potentially critical funding for States contemplating cutbacks today in those services. At the same time, you initially recognize that money alone won't solve the growing crisis in the Medicaid programs.

I look forward to hearing more from you about this plan and how we can solve the long-term problems facing Medicaid in all our States.

With respect to Medicare, the President has included—and we are very grateful—a $400 billion item in the budget over 10 years for Medicare modernization and a prescription drug benefit. The details of the President's plan obviously have not been finalized, but I think we can all agree on several points about Medicare.

First, the program needs to be modernized, with the addition of preventive benefits, catastrophic coverage, and, of course, prescription drug coverage.

Second, seniors deserve more choices in the program than the ones they currently have. At the very least, they deserve the same range of choices that Members of Congress and their staffs have through the Federal Employee Health Benefits Plan.

And, finally, we need to ensure Medicare is placed on a sound financial footing, so that future generations will have access to the program.

As the President notes in his budget, the present value of Medicare's unfunded liabilities is $13.3 trillion. That is the excess of benefits promised to future retirees over expected tax revenues to Medicare. We need to ensure that Medicare is structured in such a way that the Federal Government can continue, indeed, to support the program long term.

On issues related to bioterrorism, the President also continues to make great strides. The HHS budget allocates $3.6 billion to fight bioterrorism, including $1.6 billion for NIH, $1.4 billion for the CDC, and $618 million for HRSA, and $176 million for the FDA.

I am anxious to hear from you, Mr. Secretary, on how we will use this funding and how this country will be safer as a result.

Perhaps one of the boldest strokes in the budget is the promise of $15 billion over 5 years to combat global AIDS. I recognize that the bulk of this new money is in the U.S. Agency for International Development, but $400 million is located within HHS. I would like to hear more from the Secretary about how the entire U.S. effort on global AIDS will be coordinated.

The budget also expands access to health care for all Americans and works to improve the health of our communities. Additional funding is included for community health centers, which we are grateful for, a national health service corps, an innovative substance abuse treatment program, a disease prevention initiation, and many other laudable programs.

Once again, the President has proposed a refundable tax credit to increase health care access for uninsured Americans. We look forward to working with the administration on these initiatives.

Mr. Secretary, as always, we are grateful to have you appear before this committee. We look forward to hearing your perspective on the administration's health care priorities, and in working with you to address the important health care issues facing this country. And I thank you and yield back my time.

The Chair recognizes Mr. Waxman.

Mr. WAXMAN. Mr. Chairman, I would like to ask unanimous consent, in Mr. Dingell's absence, that the 5 minutes he would take be given to Mr. Sherrod Brown.

Chairman TAUZIN. Without objection, it is so ordered. Mr. Sherrod Brown?

Mr. BROWN. I thank my friend from California. Thank you, Mr. Chairman.

I thank the Secretary for joining us. We may not always agree, but I respect your dedication and leadership, Secretary Thompson. I wish your visit today, however, were under better circumstances. Important health programs are on the verge of being seriously damaged and critical guarantees sacrificed, rolling back decades of progress.

For example, the administration's proposed budget directly imperils two crown jewels—the two crown jewels of our health care safety net, Medicare and Medicaid, in the name of more tax cuts for the most privileged among us. Important public health priorities are critically underfunded.

Mr. Chairman, I like Secretary Thompson, but I do not like what he and others in the Bush Administration are doing to those most in need. If we don't prevent steep Medicaid cuts, coverage for 2 million beneficiaries is at risk. If we block grant Medicaid, the very program is at risk. Medicaid covers 44 million Americans; the stakes are high.

Rather than bolster Federal support for Medicaid, your budget offers States a loan, available only if they agree to take 100 percent of the responsibility for any future variation in Medicaid costs. In other words, they must agree to a block grant. With all due respect, that is a fool's bargain. It assuredly contradicts the President's stated health care goals. When you arbitrarily cutoff Federal funding, you arbitrarily cutoff access to health care.

SCHIP is a block grant, and eligible kids are sitting on waiting lists rather than getting needed health care. It is because SCHIP is a block grant that we are struggling to restore the funding needed to keep 900,000 kids insured. Offering States a loan, and tethering it to the block granting of Medicaid, is an astoundingly dismissive response to the States' budget crises.

Mr. Secretary, it displays a remarkable indifference to Medicaid's 44 million beneficiaries. Medicaid, as we know, is the largest health insurer in the United States, and it is an essential part of the Nation's health care system, our long-term care system, and our economy.

Medicaid is the only program—state or Federal—that responds when seniors in poverty need nursing home care. And because of Medicaid, 21 million children get the health care they need. Medicaid is fiscally responsible. Medicaid costs are growing at half the pace of comparable private health insurance, half the pace of private—of comparable private health insurance.

Peter King and I, along with more than 110 original co-sponsors, are introducing bipartisan legislation today that would provide a temporary increase in Federal Medicaid funding. In keeping with the President's coverage goal, this bill is designed to help stabilize access to coverage in the current economic climate, and to prevent an increase in the number of uninsured.

Mr. Secretary, I hope the President will see that block granting Medicaid actually contradicts his coverage goal. I hope you will work with us to secure passage of the King-Brown bill.

Secretary Thompson, if we do not restore the $2.7 billion in funding for the State Children's Health Insurance Program, 900,000 children, as we said before, will lose their health insurance. The President's budget would restore just one-third of the lost funding.

Chairman Tauzin and Ranking Member Dingell have introduced legislation to restore the $2.7 billion and keep those children on the restored rolls. In light of the President's health care goals, I hope you will lend your support to this effort.

Based on the President's State of the Union address, the President would require Medicare beneficiaries to enroll in private health plans in order to receive drug benefits. If you want prescription drug coverage, the President told us in the State of the Union, then you must join an HMO. This also contradicts the President's stated goal of high-quality, affordable health care for every American.

Since the original Medicare program, the original fee for service Medicare is more reliable, more flexible, and more cost efficient than private coverage, with much more extensive choice. There is only one reason to abandon Medicare in favor of insurance vouchers. It allows the Federal Government to shift more costs onto Medicare beneficiaries and on their families.

If that is not the President's goal, I hope you will explain to this committee why the President is, in fact, conditioning access to drug benefits on a senior's willingness to join a private HMO.

Finally, Mr. Secretary, on a more positive note, I want to congratulate you on being named the new Chairman of the Global Fund to Fight AIDS, TB, and Malaria. That is good news for the 42 million people around the world who have AIDS. It is good news for the 2 million that died—that will die every year from tuberculosis unless we take action. It is good news for the million people that will die of malaria every year unless we take action.

I hope under your leadership the Global Fund will come to play a more prominent role in the President's global AIDS, TB, and malaria initiatives, and I thank you.

I yield back my time, Mr. Chairman.

Chairman TAUZIN. I thank the gentleman for yielding back.

The Chair is pleased to recognize the chairman of the Health Subcommittee of our committee, Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I would yield an oral opening statement, but I do ask unanimous consent that a written one may be made a part of the record.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Good morning, I am extremely pleased to welcome the Honorable Tommy Thompson, Secretary of the U. S. Department of Health and Human Services. Mr. Secretary, I would first like to commend you on your leadership throughout the last few years. You have demonstrated remarkable capacity and ingenuity in the face of unforeseen hardships—thank you sir. In particular, your leadership has been critical in developing our nation's capacity to respond to the threat of bioterrorism. Your continued work in this area will ensure the safety and security of Americans for many years to come.

The Department of Health and Human Services (HHS) fiscal year 2004 budget continues our efforts to develop systems and programs to improve the health and welfare of our country. The HHS request includes $539 billion in total outlays—an increase of $36.9 billion, or 7.3% over the requested fiscal year 2003 levels. I am

pleased that the budget continues to build on your significant request last year for new funding to combat bioterrorism. While some might argue that the Administration has proposed reducing the department's funding for bioterrorism, I would point out that the Administration's request of $3.6 billion for HHS's bioterrorism activities is in addition to the funding that HHS is planning to transfer to the new Homeland Security Department. Furthermore, it is important to note that another reason for the perceived decrease was because many of the needed facility updates that were included in last year's budget request addressed one-time only needs. Also, I am very eager to learn more about project Bioshield. I have no doubt that we can all agree that the best policy in this area is one of prevention.

I would also like to thank you and President Bush for focusing on improving access to health care and modernizing Medicare. As you know, last year we passed a Medicare prescription drug package that would have moved the ball forward on this issue. Unfortunately, the Senate was unable to act. This year you and the President have put a great deal of resources on the table—$400 billion to be exact, and I believe that we can develop legislation to meet all of our needs in this area. It is so vitally important that we take steps now to deliver prescription drugs to our nations seniors in a manner that is fiscally responsible. I look forward to working with you Mr. Secretary as the details of this proposal are developed and moved through the Congress.

The budget also outlines a proposal to provide new resources to help strengthen and reform the Medicaid program. As we all are aware many states are in the midst of a severe budget crisis, with their Medicaid costs growing at astronomical rates. I believe that part of the problem is that we have not taken a comprehensive look at this program for some time, which I plan to do over the next several months. I am very pleased that the Administration is committing substantial resources to this effort by requesting $3.4 billion for fiscal year 2004. These resources will enable us to help states in the short term while at the same time implement reforms that will hopefully ensure the long-term viability the program. I look forward to working with you and your staff as these ideas become more refined over the next several months.

I would also like to thank you Mr. Secretary for requesting an increase to the Community Health Center program. I have long been a supporter of this program and believe that they are a vital component in helping us battle the problems of the uninsured. I think that the $169 million increase to this program will bring us closer to the goals of expanding the treatment capacity of health centers to treat an additional 6 million people by 2006.

Mr. Secretary, as always the members of this Committee and I look forward to working closely with you and the President to address the healthcare challenges we are facing at the dawn of the 21st century. We must protect our nation against bioterrorism, help the uninsured, improve our health care system, and modernize Medicare. Thank you, Mr. Chairman. I yield back the balance of my time.

Chairman TAUZIN. The gentleman makes a unanimous consent that all written statements be made a part of the record. Without objection, it is so ordered. The gentleman yields his 3 minutes and reserves it for questioning. Is that correct?

Mr. BILIRAKIS. That is correct.

Chairman TAUZIN. Then, the Chair will recognize in order Mr. Waxman from California.

Mr. WAXMAN. Mr. Chairman, I want to get in on this new deal of adding question period time. So I will waive my opening statement.

Chairman TAUZIN. The Chair recognizes Mr. Upton from Michigan.

Mr. UPTON. Defer.

Chairman TAUZIN. Also defers. This is working.

The Chair recognizes the gentleman——

Mr. TOWNS. Defer.

Chairman TAUZIN. The gentleman from New York defers. That is a good idea.

On this side? Let me ask maybe to make it easier, is it the chairman's understanding that all members who do not wish to give

their opening statement at this point want their 3 minutes in questioning? Does anybody not want their 3 minutes? I think everybody does.

And does anybody desire to make an opening statement at this time? The gentleman Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. I am going to use my time this morning to discuss three major program areas in which I am concerned that the budget would severely undermine our country's health care safety net. These three areas are the budget's proposals for Medicare, Medicaid, and the Substance Abuse and Mental Health Treatment Services Administration.

Secretary Thompson, in your budget, you emphasize the importance of offering a prescription drug benefit to Medicare beneficiaries, and it is clear that you understand the importance of adding prescription drug coverage. However, I am very concerned that under your proposal seniors will be forced to join a private insurance plan in order to get prescription drug coverage.

In my district, largely rural, private plans just haven't worked. Nearly all Medicare Plus Choice plans have left my district since it is more expensive to provide care to seniors in rural areas. It would be unfair to coerce seniors into leaving traditional Medicare by offering prescription drug coverage only through a private plan that may or may not be accessible to all.

Instead, we must act this year to include a voluntary prescription drug benefit that is a part of the fee for service Medicare and that doesn't force beneficiaries to choose between affordable, reliable, traditional Medicare coverage and a private plan with prescription drug coverage.

I am also concerned about the budget's proposal to change the Medicaid program. Medicaid serves more than 40 million beneficiaries, providing health care services for low-income children, families, pregnant women, long-term care services for the elderly and disabled, and assistance with the cost of Medicare for low-income seniors.

Now States are facing budget shortfalls and rapidly rising health care costs that make it more difficult to operate these Medicaid programs. Although the budget's references to increasing flexibility and reducing administrative burden on States may sound as though we will provide help to States in these tough times, the proposal will really just allow States to block grant Medicaid and CHIP, and these dollars will be into a single allotment that would not provide States the help they need to continue to provide these quality services and benefits to the most vulnerable of our population.

Finally, I am pleased that the budget commits more money to substance abuse treatment in the form of $199 million in new funds, but I am concerned that these funds will not be used effectively. As a psychologist, I know first hand the tremendous need in this country for mental health and substance abuse treatment services.

Individuals struggling with mental illness and substance abuse problems or, more often, a combination of substance abuse and mental illness, frequently find it difficult to obtain quality care. As a result, it is difficult for some to hold down a steady job that pro-

vides health insurance, and, consequently, many mentally ill individuals sadly are in our prison systems or living on the streets or in our homeless shelters.

When I have time for questions, I hope to learn from you, Mr. Secretary, how you intend to assure that the providers covered by the voucher program proposed by your budget are trained to provide substance abuse counseling services.

Chairman TAUZIN. The gentleman's time has expired.

Mr. STRICKLAND. I yield back whatever time I have. Thank you.

Chairman TAUZIN. The gentleman yields back.

Is there a request for an opening statement on this side? Then, the gentlelady Ms. DeGette is recognized.

Ms. DEGETTE. Thank you, Mr. Chairman.

I want to add my thanks to the Secretary for coming today. I know you work very hard on these issues. But in my view, at no time will there be a greater need for the Federal Government to provide leadership and dollars to help the States close the huge gaps in funding they are currently facing.

All of the States are under tremendous budget pressures. And, for example, in my home State of Colorado, we have an $850 million deficit. Much is due to rising health care costs. So to help close this gap, our Republican-controlled State House Committee voted this last Monday to eliminate Medicaid coverage for legal immigrants.

If this bill receives approval, we will be the first, but I will guarantee you not the last, to strip Medicaid coverage based on citizens. And it will not be one of our State's finest hours or one of this country's finest hours if we exclude those who are here legally.

The President's budget does nothing to help this situation, because it adds no additional funds to States to help with Medicaid shortfalls or, frankly, with shortfalls to disproportionate share hospitals which are suffering because they are treating increasing numbers of the uninsured. But that is not what I want to talk about today.

I have so many problems with this budget, but there is something that is going to appall the American people when they find out about it, and that is the paltry increase in funding for the National Institutes for Health. In the administration's proposed fiscal year 2004 budget, there is only a 2-percent increase in NIH funding over fiscal year 2003 levels, which will disrupt the dramatic research progress that we have made, frankly, in a bipartisan fashion so far.

Congress has nearly completed its effort to double the NIH budget. These funds have greatly helped us come much closer to treatments and cures for many diseases, from sequencing the human genome to developing eyelet cell transplantation. The rewards of our public investment in financed research programs continue to increase exponentially and help the quality of life.

Let me just give a couple of examples. In 1970, the number of Americans killed by heart attacks peaked at—or heart disease peaked at 1.3 million people. By 2000, that number had been reduced by over half. That year, fewer than 515,000 Americans died from coronary diseases. Advances made in one area of human health, as you know, often lead to advances in other areas.

Cholesterol lowering drugs, known as statins, appear to have contributed to an unexpected lowering of the risk of stroke, and on and on. By reducing the public NIH funding, as the President has proposed, we will be backsliding in these and other areas.

While the President's budget does provide additional funding for bioterrorism detection analysis—and that is good—we cannot sacrifice this important vital research for these other programs.

So, Mr. Secretary, I see you nodding. I would hope we can work together in a bipartisan fashion to restore this important research funding.

Chairman TAUZIN. The gentlelady's time has expired.

Further requests for opening statements on this side? Mr. Stearns?

Mr. STEARNS. Thank you, Mr. Chairman.

I am going to use my opening statement to welcome the Secretary and just tell him that in Florida we have a program that you know about. We are calling it Family Directive Services, which was Cash and Counseling.

And I just gave a speech on the floor, Mr. Chairman, and bring that to the attention of Americans, that in these States there has been flexibility provided with waivers. And these waivers allow families in Medicaid to have a choice, and this choice can be one to go into Family Directive Service, which allows them to select and to use the doctors in the private sector. And at the same time, if they don't want to go into the Family Directive Service, they don't have to.

This has been very successful in the State of Florida. Governor Jeb Bush has offered this, and I think the Secretary should be commended for influencing and providing these kind of programs, because we get a better bang for the buck. And, ultimately, the people in Medicaid get to be personally responsible for their health care and the decision process in the family.

And so, Mr. Secretary, I think that is a very good program, and hopefully we will hear some more about it.

Chairman TAUZIN. Thank you.

Mr. STEARNS. I yield back, Mr. Chairman.

Chairman TAUZIN. The gentleman yields back his time.

Further requests on this side? Ms. Capps?

Ms. CAPPS. Mr. Chairman, thank you. I wanted to strike a bargain with you to delete from my opening statement the points that have already been covered by my colleague, but retain—and that takes care of Ms. DeGette's comments on the NIH and Mr. Strickland's about what will happen in rural parts of this country when seniors find private insurers not wanting to deal with their prescription drug needs, and Mr. Brown talking about Medicaid—the dissembling of it.

But I want to thank you. This is my chance to thank you for your support, and the administration's, on dealing with our legislation to deal with the nursing shortage. But I—and I was impressed even with the rhetoric in the budget documents released by the Department on this issue, but I was disappointed to see that the funding requested doesn't match this rhetoric.

It looks like in this budget there are—one program's budget is cut in order to give money to another program. And overall spend-

ing on nursing programs is actually slightly cut from the President's fiscal year 2003 request, and well below what was included in the Senate version of the Omnibus bill.

What we need to do now is increase funding for nursing programs so that we can address the national nursing shortage. We have to spend more on this priority, and you and I have talked personally about what this does about our homeland security issues. The two are very intricately connected.

This shortage will not alleviate itself on its own. And until it is addressed on its own, and until it is addressed from the Federal Government, it is not going to be possible for the communities to deal with it.

I am hopeful to continue this conversation with you during the question time, and thank you for being with us today.

I yield back.

Chairman TAUZIN. The gentlelady yields back.

The gentlelady Ms. Wilson seeks recognition.

Ms. WILSON. Thank you, Mr. Chairman. I would like to forego my opening statement and ask additional questions at that time.

Chairman TAUZIN. The gentlelady is entitled to do that, and will be so recognized.

On this side, the gentlelady from California seeks recognition. Ms. Eshoo?

Ms. ESHOO. Thank you, Mr. Chairman, and good morning, and welcome, Mr. Secretary.

I think I can usually find something positive in almost everything, or at least I try to. But I am really struggling to find the good news in this year's budget proposal and the administration's health care program.

I represent a very, very—everyone thinks they represent a distinguished Congressional district. Mine is home to Stanford University, to Silicon Valley. It is an area that has produced much for the country.

And I am here to tell you that people are hurting. And my objections to the direction that the administration is going is to use words to dress up something that I believe is very hurtful. Whether it is called block grant, whether it is called voucher, if, in fact, this is taking a walk from helping people that have become so vulnerable because of what is happening in our country today, it is just wrong. It is just wrong.

And I think that it moves against what has made this country strong, and that is that we are usually, and almost always, in this together. And so I understand that budgets are always debated, budgets are tough to come up with, but when a block grant for 10 years—let us talk about 10 years to the States—the Federal Government in this block grant relative to Medicaid is saying, "So long." It is like pushing a boat with children in it out into the middle of the ocean, and it is not fair.

Now, you were a Governor. You know the pressures that States have. You know the pressures that States have. On our side of the aisle, it is why members fought and felt very strongly that in our economic stimulus package we would help States with Medicaid funding. And this block grant, no matter how you dress it up and walk it around, it is a cut, and it is going to hurt.

And then we say it is optional. It is optional. Well, guess what is going to happen with the option? The Governors don't have the money. People are not going to get the services. I think that we can do much better than this.

When we have an orange or a red warning in this country relative to our own security, you know what? I think the top color light should be blinking on and off relative to health care. I have unemployed workers that were engineers in Silicon Valley that can't afford their COBRA, are getting $300-and-some-odd a week in unemployment, can't find a job, and don't have health care. That is the face of one of the most upscale important places in our country.

So I thank you for your public service, and I couldn't mean that more. But I find——

Chairman TAUZIN. The gentlelady's time——

Ms. ESHOO. [continuing] the proposals of the administration——

Chairman TAUZIN. [continuing] has——

Ms. ESHOO. [continuing] to be so short——

Chairman TAUZIN. [continuing] expired.

Ms. ESHOO. [continuing] for the American people, that I have used my opening statement to describe it.

Chairman TAUZIN. The gentlelady's——

Ms. ESHOO. Thank you very much.

Chairman TAUZIN. Thank the gentlelady.

Further requests for opening statements on this side?

Mr. ALLEN. Mr. Chairman?

Chairman TAUZIN. Mr. Davis is recognized. Mr. Allen, I am sorry.

Mr. ALLEN. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here today to explain the President's budget.

I just wanted to take a few moments—every time I look at the administration's proposal for Medicare reform, and every time I hear the word "choice," I want to put the asterisk in and the footnote which says, "This means that seniors' health care will get turned over to private insurance companies," because I think when you say that, it clarifies what is going on.

It seems to me that to give seniors—to transform traditional Medicare, and basically try to move people off traditional Medicare into private insurance companies, is a bad bargain for the elderly. The reason that Medicare was created in 1965 was because the private insurance market had trouble covering older and sicker people.

Right now, Medicare has a kind of stability and predictability and continuity that our seniors need and deserve, and that would be undermined. If we look at the—by the administration's proposals. If we look at the experience of Medicare Plus Choice, what we see is in some—you know, in some years maybe you get it, maybe you don't. Some States, some counties, maybe you get it, maybe you don't.

The benefits can change every year. The premiums can change every year. The co-pays can change every year. I believe the administration's proposals are an attempt to transform Medicare into maybe-care. And it is the wrong way to go for our seniors.

My parents a few years ago, when they were on—in their mid eighties, they were on a managed care Medicare plan in the State of Maine. And I can tell you it was a disaster. It was a disaster because what private insurance companies do is they deny benefits, and that is how they are trying to save money. And for people in their eighties, that is a very bad deal.

There are no Medicare managed care plans left in the State of Maine or in about 15 other States, last I knew. This Medicare reform proposal will, if it works at all, would only work in more urban areas. It would not be helpful, in my opinion, to more rural areas in this country. And I would urge the administration to rethink this proposal, to explain how your Medicare reform proposal connects with your proposed prescription drug plan. Those are some of the areas that I think we need to discuss today, but I do very much appreciate your being here.

And, Mr. Chairman, I yield back the balance of my time.

Chairman TAUZIN. The gentleman's time has expired. The Chair thanks the gentleman.

The gentleman from California Mr. Cox is recognized.

Mr. COX. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

There is no more important reason for the Federal Government, and no more important responsibility of the Federal Government, than protecting these United States from attack. Your Department heretofore has been devoted to protecting Americans from the scourges of poverty and disease, and now you have been enlisted on the front line of our fight against terrorists who are using disease as a weapon.

And in that connection, you have asked for over $3.5 billion for a bioterrorism initiative that I believe this committee will strongly support. And I know on the Homeland Security Committee we will strongly support this.

Your budget proposal is aimed in three separate directions. First, expanding ongoing medical research; second, State and local preparedness funding; and, of course, responding to attacks if we cannot prevent them is immediately job one; and, third, measures directed to protecting our food supply.

I also note that you are seeking to dramatically expand NIH research funding that is needed to develop vaccines, and I appreciate that. We need medicines that will make biologic agents much less effective as weapons of attack against Americans.

And I know that you are going to be seeking funding so that HHS can continue to manage the strategic national stockpile and provide scientific and public health direction needed to ensure that the pharmaceutical stockpiles include proper amounts of drugs, vaccine, and other biologics.

Beyond all of this, a portion of the funding that you are going to be responsible for lies without the budget of HHS and will be within the budget of the Department of Homeland Security; specifically, Project Bioshield, which you and I and the President and others kicked off up at NIH just a few days ago.

This is intended to bring together the resources of the government, so that we can be more successful than we needed to be in the past in developing defenses against bioterror. I am particularly

interested in seeing that the Department, which is notwithstanding that the funding is going to be located at Department of Homeland Security, which is going to be responsible for providing the scientific direction and carrying out the actual procurement, that the Department is successful in its efforts to provide more flexible contracting and procurement authorities for critical biodefense work.

So I want to encourage you. I note that while people are talking about the size of your budget that just the portion that you have asked for for bioterrorism works out to nearly $100 for the average American household. So if we can imagine going door to door and asking for $100 from you and $100 from you and $100 from you, all across this country, that is what we are doing just for this small portion of your budget.

It is an extraordinary amount of money, an extraordinary commitment. We haven't had to spend this in the past.

Chairman TAUZIN. The gentleman's time——

Mr. COX. We now do need to spend it, so thank you very much, Mr. Secretary——

Chairman TAUZIN. [continuing] has expired.

Mr. COX. [continuing] for being here. And I thank you, Mr. Chairman.

Chairman TAUZIN. I thank the gentleman.

Who seeks recognition on this side? Mr. Davis?

Mr. DAVIS. Thank you, Mr. Chairman.

Chairman TAUZIN. The gentleman is recognized for 3 minutes.

Mr. DAVIS. Welcome, Mr. Secretary. Your experience and insight as a Governor will be particularly useful to us in judging the impact of what is being proposed today on the people we are all here to represent. I hope you will address the points I am about to raise in your oral testimony, and if you don't have time, and I don't have time to cover it, perhaps your office can follow up in writing.

No. 1, I would like to know which Governors are asking you for the flexibility that you are offering and the way you have tied it together.

No. 2, I would like to know what examples you can cite to us as to how States have used waivers, and the kind of flexibility you are offering, and how that has genuinely improved the lives of people and the delivery of governmental services as far as health care.

And the third thing is that you apparently are thinking about tying the drug benefit into a PPO model of delivery, which means the beneficiary will probably have to pay an additional cost for the privilege of being in a PPO versus an HMO. And if that is the case, we need to have the details in terms of the additional cost to the people we represent for the privilege of having their own doctor as well as this drug benefit.

Thank you, Mr. Secretary.

Chairman TAUZIN. The Chair thanks the gentleman.

The gentleman Mr. Walden is recognized for 3 minutes.

Mr. WALDEN. Thank you very much, Mr. Chairman.

Mr. Secretary, I am delighted that you are here to join us today. I sat here listening to some of the debate, and this is probably the only place on the planet where spending can go up nearly $37 billion, and we would think that we are somehow slashing government.

As I looked at some of these proposals, Mr. Secretary, I want to commend you, because I think they go a long way toward getting at what a lot of us want to solve, and that is making sure people, regardless of where they live, have access to affordable health care in their communities and in their areas.

And I look at this in the community health centers—$169 million in the President's budget to enable the program to expand services to an additional 1.2 million people at 120 new sites. Those community health centers are very important, very valuable, and will be very effective.

The budget includes $24 million for the National Health Service Corps, to do something we have worked hard at in Oregon, and that is to try and get medical providers to locate and serve underserved areas in remote rural areas. I have three counties in my district that don't even have a doctor or a hospital. It is literally a hundred miles or so to the nearest.

And so our efforts to try and bring health care into rural areas is something I worked on hard when I was in the legislature and will continue to do so here, and I commend you for the efforts on the National Health Service Corps.

Substance abuse treatment—the budget includes $199 million in new funding for a new State program that would enable 100,000 additional people to receive drug treatment services. Wherever you go in that area, people are saying, "We need access. We need more health." And certainly you are trying to come up with a program to do that.

One hundred million dollars in new funding to tackle the scourge of diabetes, obesity, and asthma, you know, we are talking 50,000 asthma-related hospitalizations would be prevented here perhaps. Seventy-five thousand Americans would be helped from developing diabetes, and perhaps prevent 100,000 Americans from the problems with obesity.

And importantly is improving the access to generic drugs. The additional $13 million for the FDA to speed generic drug reviews means lower drug costs for all of us, not just senior citizens.

And so, Mr. Chairman, and Mr. Secretary, as I look through some of these things, certainly we will have our discussions, we will have our debates, but let us not forget that a lot of new money is being put toward solving the problems that all of us would like to see solved. And I commend you and the President for your leadership in this area, and look forward to working with you to improve health care for all Americans.

Thank you, Mr. Chairman.

Chairman TAUZIN. The Chair thanks the gentleman.

Any further requests for opening statements? The gentlelady Ms. Schakowsky is recognized.

Ms. SCHAKOWSKY. Thank you so much, Mr. Chairman.

Mr. Secretary, welcome. I share your goal of improving health and safety of our Nation, and I am anxious to work with you on that effort.

I believe that our great country needs to do more to prevent and respond to public health threats posed by terrorists, but that we must not do so by sacrificing progress toward meeting ongoing health needs at home. Not only can we accomplish both goals, but

we can—we must do so. And as the President said, failure is not an option.

This committee has a long record of working to improve our Nation's health care, particularly through programs like Medicare, Medicaid, the Child Health Insurance Program, and I believe that we must improve these programs. We must add an affordable comprehensive drug benefit to Medicare. We must open up Medicaid to more populations who are being denied affordable access, or indeed any access in the private market. We must preserve the CHIP program and expand it, so that every child can receive medical care.

And while we certainly can improve these public initiatives, I believe that we have to be proud of them and recognize their successful track record. They have met critical needs and done so more cost effectively, in fact, than any private market insurer.

While we are all eager to hear the details of the administration's plans regarding Medicare and Medicaid, I have to tell you that I am deeply concerned about everything that I have heard so far. I hope that you will tell us today that the President has decided to provide a meaningful drug benefit in Medicare available to all beneficiaries, whether they enroll in a private plan or not. I believe it is wrong to pretend that we are solving this problem by making a drug benefit available only to those who enroll in a private insurance option.

I am also deeply concerned about the Hobson's Choice being offered the States from Medicaid. I believe that we should be increasing the Federal match, no doubt, but I do not believe that any increase should be linked to a cap in future years or that States should be given the authority to increase cost-sharing requirements or vary benefits from one beneficiary to another.

I am concerned I see no mention of efforts to improve nursing home quality by implementing staff ratios, improving the Ombudsman Program, or beefing up enforcement.

As the former Director of the Illinois State Council of Senior Citizens, I hope to work with you closely on these and other long-term care issues.

I am pleased to see a proposal by the administration to increase home- and community-based options for persons with disabilities, but I believe it is more than a question of dollars following the individual. It is also a question of providing adequate dollars and adequate implementation of the Olmstead decision. I hope to work with you on that.

And, finally, I have spent a lot of time dealing with my public health departments and health care providers. They are concerned about a tremendous void in Federal assistance, and I hope that we are not making—we are not forcing a choice between protecting the homeland and protecting our communities. It is a false choice, a dangerous choice. Homeland and hometown security are one in the same.

I am so happy to be here as a new member of this committee and am eager to work with you, Mr. Secretary, wherever possible to meet our Nation's health care needs.

Chairman TAUZIN. The gentlelady's time has expired, and the Chair thanks the gentlelady.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Chairman TAUZIN. Further requests for opening statements? The gentlelady Ms. Solis is recognized for 3 minutes.

Ms. SOLIS. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here today to help explain and kind of work us through this proposal that the President has proposed.

First of all, I want to say thank you for coming to Los Angeles and for providing some very necessary relief that we have been working on for a number of years. But I do want to say that I am very—equally concerned with the enormity of the problem and issues that we face in Los Angeles as well as in the State of California. Eleven of those clinics in Los Angeles were closed, three of which served my area.

We are looking and hoping that we can receive funds so that we can acquire Federal dollars to help provide support for those clinics that were closed.

On an average basis, one of those clinics alone in the city of Azusa tends to about 40,000 people. And we are talking about the working poor. We are not talking about people who are just off the street that don't have jobs. I am equally concerned that many of our young children in this area are not going to be receiving adequate prenatal care that is very necessary.

Some of the programs that I have read about that you are looking at giving flexibility to the States to handle—optional programs—right now in the State of California are very, very good, meaningful programs that have actually expanded care to legal immigrants, to their families and to children.

In our State of California, which is faced with a tremendous deficit right now, as you well know, I think those are going to be the first things that get off the table. And I am very concerned about your commitment and want to know what your thoughts are on that, if you will support States that are already doing that.

And I would be very, very concerned also to hear an explanation more about why there has been a reduction in, for example, the environmental health programs. And the reduction that I saw in one of the budget pages, a document that you provided us, a $2 million reduction in environmental health funding to the CDC.

I am very concerned because in my district we have contaminants, we have five waste facilities, two Superfund sites, and we have heavy cases of asthma. Over 36,000 children surrounding my area are afflicted with asthma. I would like to know what we are going to do to provide the tools and instruments to help remediate these problems that we face.

I know there has been a lot of good questions that have been asked, so I will yield back the balance of my time.

Chairman TAUZIN. The gentlelady yields back.

Further requests for opening statements? The Chair sees none, hears none. And the time for opening statements has concluded, which means that any members arriving hereafter will be limited to a 5-minute round of questioning. And those who have given opening statements will be likewise limited.

[Additional statements submitted for the record follow:]

Prepared Statement of Hon. Paul E. Gillmor, a Representative in Congress from the State of Ohio

I thank the Chairman for the opportunity to review the Administration's FY2004 health care budget and priorities, and certainly applaud the President's initiatives aimed at promoting a healthier America. Furthermore, I look forward to learning more about the Administration's Medicare reform plan over the next several weeks.

On another note, I would like to quickly add a "thank-you" to Secretary Thompson. One of Ohio's major companies, Procter & Gamble, has had a food additive petition pending before the Food & Drug Administration (FDA) since December 1999. The petition is to remove the warning label on products containing olestra, a noncalorie fat substitute approved to use in snack foods that has been clinically shown to help people lose weight. In mid-1998, the FDA's Foods Advisory Committee reviewed data re-confirming the safety of olestra, demonstrating that the product did not cause adverse gastrointestinal or vitamin effects, and further concluding that the warning label is misleading to consumers and should be changed.

Last month, Proctor & Gamble learned after much delay that the FDA is moving to complete action on the requested petition. Again, I thank you for your efforts and ask that the FDA move as expeditiously as possible to complete action on the petition.

I look forward to hearing your testimony, and yield back the remainder of my time.

Prepared Statement of Hon. John Shimkus, a Representative in Congress from the State of Illinois

Thank you Mr. Chairman for holding this important hearing today. I am pleased we are taking this time to discuss the President's impressive health care agenda and how the 108th Congress can work to lay the foundation for more successful health care programs with greater equity, accessibility and coverage.

Any health care program that Congress develops or attempts to reform must maintain equity in terms of benefits, cost, and accessibility among its beneficiaries. Individuals should not be disadvantaged or advantaged merely because of where they live. Rural beneficiaries should have the opportunities to enroll in plans that are comparable to those available in urban areas.

We need to design a Medicare program that promotes the highest attainable quality of care for all beneficiaries. A prescription drug benefit must include quality standards and programs to improve rural health outcomes. Rural provider organizations need access to mechanisms for training personnel and implementing rural-appropriate improvement systems. Rural areas must also have access to resources to acquire and further develop information systems.

I applaud the efforts already underway by the Southern Illinois University School of Medicine in developing their Telehealth initiative. Telehealth delivers health care, health education and health community outreach programs over wide distances using information and telecommunications technology. Telehealth can dramatically improve access to health care in underserved areas and balance the distribution of health professionals among rural and urban areas. Based on SIU's success in making health care more accessible in rural and underserved areas, I look forward to addressing the recruitment and retention of health professionals in all fields and locations in the 108th Congress.

With 41.2 million Americans lacking health insurance, a serious effort is also necessary to reform the individual insurance market and ensure more viable health insurance options for consumers. The situation is especially critical in rural and underserved areas. Association Health Plans (AHPs) can help address this issue by injecting new competition into the market and providing all areas with greater options in terms of insurance. AHPs will allow workers in small businesses and the self-employed to join together to obtain the same purchasing clout and cost savings that employees of large corporations and labor unions currently enjoy. Studies estimates that as many as 8.5 million of those currently uninsured would gain access to private sector health insurance through AHPs.

Finally, I would like to commend the Administrations efforts to increase funding for Community Health Centers by $169 million. This will enable the program to expand services to additional 1.2 million people at approximately 120 new sites. I have had the opportunity to observe the benefits of this important program up close; the center operating in Springfield, Illinois has made vital health services available to the community.

It is absolutely crucial to improve health care access and services to all Americans especially those living in rural and medically underserved areas. I hope this hearing will enlighten us all on how to do just that.

PREPARED STATEMENT OF HON. C.L. "BUTCH" OTTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

I would like to thank the chairman for holding this hearing today and I appreciate his leadership on this issue. I am also pleased by the efforts of Secretary Thompson and the administration in their persistence on the Medicare and Medicaid reform issues.

The notion that it is always cheaper to provide healthcare in rural areas is now outdated and inaccurate. Rural areas face unique challenges in delivering quality affordable healthcare. Great geographic distances, low populations, and limited services create increased obstacles and added expenses in providing care. Despite these challenges, disparities in wage factors and geographic adjustments in Medicare reimbursement formulas continue to put rural Medicare providers at a considerable financial disadvantage. While I am encouraged efforts were made in this year's omnibus appropriations bill to provide a temporary fix to some of these problems, a long-term solution has yet to be reached.

In Idaho, the number of medical providers accepting Medicare patients is dwindling. In addition to low reimbursement rates, there are a number of factors that have contributed to this problem including an increase in required documentation, intrusive fraud and abuse investigations, and high medical liability claims. Any reformation of the Medicare program must be provider responsive in addition to providing seniors with updated insurance benefits.

Many rural states, including Idaho, are cutting optional Medicaid programs as a way to deal with their declining budgets. According to the Government Accounting Office (GAO), Medicaid spending accounts for about 15 to 20 percent of all state spending, second only to Education spending. The aged and disabled account for approximately 27 percent of all Medicaid enrollees, yet make up 66 percent of all Medicaid expenditures. Long-term care and prescription drugs for this demographic accounts for much of the disparity. Medicaid is now the single largest funding source for long-term care. The Federal government must create incentives for individuals to purchase long-term care insurance, and for families to play an active role in providing, or funding, long-term care.

States are also spending a large portion of their Federal Medical Assistance Percentage (FMAP) for Medicaid on prescription drugs. Shifting the burden of prescription drugs for low-income seniors from Medicaid to Medicare will mean significant savings for states. The Medicare Modernization and Prescription Drug Act, as passed last year by the House, would have saved states in the order of $44 billion over the next 10 years. It is imperative we work toward creating a responsible Medicare prescription drug benefit for seniors.

Responsible and meaningful reforms to the Medicare and Medicaid programs are achievable. However, the baby boom generation continues to age and comprehensive reform to these programs still looms as a necessary step in updating our health system to meet the needs of modern society.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am pleased to cosponsor and support the Patient Safety and Quality Improvement Act. I commend you, Chairman Bilirakis, and Rep. Brown for your work on this bill. We reported a similar bill in the last Congress.

According to a December 2003 survey by the Harvard School of Public Health and the Kaiser Family Foundation, 42 percent of the public says that they or a family member have experienced a medical error. Some government agencies and private-sector organizations have been pioneers in their efforts to improve patient safety. Now is the time for Congress to produce a coordinated initiative. This bill takes an important first step by creating a voluntary reporting system for the purpose of analyzing and learning from medical errors.

Under this voluntary reporting system, health care providers could freely discuss medical errors with Patient Safety Organizations, determine what went wrong, and identify what changes need to be made to prevent future mistakes. The bill balances providers' need for confidentiality with the public's right to access information. All information that is available to patients today would continue to be available to them in the future.

The bill would allow different Patient Safety Organizations to share knowledge with each other and the Agency for Health Research and Quality. In turn, the Secretary of Health and Human Services would use this information to identify which strategies for reducing medical errors should be used in federally funded health programs.

Our underlying goal is to improve care for patients, and we intend for this bill to encourage the health care sector to make improvements the public can see. Again, I commend my colleagues for their cooperation on this bipartisan bill.

PREPARED STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Good Morning. I'd like to thank Chairman Tauzin for calling this important hearing.

Mr. Secretary, I think that the President's budget does a pretty good job of laying out this Administration's priorities with respect to health care. Unfortunately, the message that the Administration's budget sends is, "Sorry Grandma and Grandpa, but our tax cuts trump your Medicare and Medicaid."

The Bush tax-cuts are not only undermining health care now, but are leading us into a health care crisis—particularly for the many seniors who are in need of long-term care or struggling to afford rising prescription drug costs, and the Bush Administration has been doing little to help them.

The Bush Administration is now proposing to further privatize Medicaid and Medicare. But Medicare+Choice was a failed experiment that does not warrant repeating but should be shown the door. The private sector profits by taking care of the healthy and the wealthy. But insurance companies often lose money serving the poorest and the sickest. That is why we have Medicare and Medicaid—to ensure a health care safety net for populations which may prove too "costly" for the private sector to cover. Medicaid pays for 1 out of every 3 births in our country and 65% of all nursing home patients and is a vital program to this society and deserves to receive adequate funding.

Medicare+Choice failed in Massachusetts and around the country because proposed cost savings have never been delivered, while the increasing costs of health care have lead to huge premiums which have made Medicare+Choice unaffordable to many. In my home state, these plans could not build adequate physician networks and limited service to those areas of the state considered to be the most profitable. In my District, Cities like Everett, Revere, and Winthop lost coverage as Medicare+Choice withdrew. It's time to recognize that this was a failed experiment.

Instead of learning from the mistakes of the past, the Bush Administration is now proposing to repeat them on a much larger scale. The Bush Administration is trying to extort seniors into these privatized plans by adding an inadequate drug benefit. In addition, the Bush Administration is proposing new "flexibility" in how Medicaid services are delivered. Sounds good, but what does it mean? What it means is states may be given greater latitude to cut non-mandatory services, increase cost-sharing, or reduce eligibility to balance their State's budget. Under the Administration's proposal, if States want to receive slightly more money they can receive a block grant. However, the amount of funding provided for these block grants is inadequate, since it fails to account for likely increases in the patient population or increased health care needs. In addition, in the eighth, ninth, and tenth years of this program, the states have to pay all of the block grants back. Where is that money going to come from? State budget cuts? State tax increases? The Bush Administration is essentially proposing an intergenerational "punt" that will force our children to pick up these costs just as the Baby Boomers enter retirement.

How will our nursing homes fare under the Bush plan? Medicaid pays for half of all nursing home expenditures. Nursing homes in Massachusetts already receive inadequate Medicaid rates—rates that are $20/day below cost—and have lost money every year since 1994. How many private industries will invest in a business with that kind of track record? Not enough to cover our greatest generation and not enough to cover the baby boomers. It is the Federal and State's obligation to ensure that our nursing home thrive and provide the highest quality of care. This will only occur with increases in Medicaid spending. While I agree that alternatives to institutionalization, such as those proposed in New Freedom Initiatives, are important. But we cannot neglect the need for nursing home care and we should not allow this existing infrastructure to crumble. In our efforts to promote home health care we must provide allow enough money to provide for all the necessary services and these are all not covered in the President's budget. That money is being spend on tax cuts that disproportionately benefit the wealthy.

The irony of the New Freedom Initiatives is that the Bush Administration supports the homebound definition in Medicare law that restricts the length and frequency of a home health beneficiary's absences from the home without changing the conditional requirements. The current "homebound" definition forces patients to choose crucial home health care over fundamental freedom. I have proposed legislation that is being held up because of disputes about the costs. Secretary Thompson, I have repeatedly asked HHS and CMS to invest this issue and I have not yet seen any data to support the claims of the extraordinary costs that the CBO has reported, which directly conflict with the GAO's report.

I am also concerned that this Administration has started a vaccination program for smallpox which asks our health care workers to volunteer to serve their country by building up immunity to this deadly pathogen while there is not an adequate safety net in terms of compensation for those who will suffer adverse side-effects, which were not due to negligence but will occur normally with this vaccination.

This year is a critical year for maintaining and building upon our national security but also national health care coverage, providing prescription drug coverage to all people, covering the uninsured, reimbursing our providers adequately, and providing universal fundamental freedoms for those who seek medical treatment and health care coverage, such as protecting their health information and easing up harsh restrictions for homebound patients. I look forward to exploring how best to achieve these goals with the Secretary today.

Prepared Statement of Hon. Ed Towns, a Representative in Congress from the State of New York

Secretary Thompson, while I join my colleagues in expressing deep concerns about the Administration's reform proposals concerning Medicare, Medicaid and the S-CHIP program, I was pleased that the President's budget contains significant funding increases for substance abuse treatment. I believe that the President's initiative is a good start towards addressing the nation's critical lack of access to substance abuse treatment. As a former drug rehabilitation clinic administrator, I am convinced that we could exponentially increase the impact of the Recovery Now Initiative if the Administration would couple this proposal with a similar initiative on the private sector side.

As you know, for the last three Congresses, legislation that would require private insurance plans to treat addiction like any other medical illness under a health plan has enjoyed strong bipartisan support. I believe that proposing the Recovery Now Initiative without addressing the issue of substance abuse parity in the private sector diminishes a valuable opportunity to make treatment in both the private and public sectors more widely available. By requiring private insurance companies or employers to provide the access to coverage for addiction treatment to their plan participants, we can better utilize public resources including the new funding in the President's Recovery Now Initiative. Mr. Secretary, I congratulate you and the President on this innovative substance abuse program and hope you will couple it with the inclusion of substance abuse parity. I yield back the balance of my time.

Prepared Statement of Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey

Thank you, Mr. Chairman, for holding this hearing on the Department of Health and Human Service's budget priorities for Fiscal Year 2004.

President Bush's 2004 budget is proof that health care is not a priority of this Administration. Furthermore, the Administration has taken up the task of single-handedly dismantling nearly every safety net health care program in the United States. Unfortunately, without dramatic changes made by Congress during the budget and appropriations process, more Americans—children, adults and the elderly—will be uninsured and under-insured due to the President's Medicaid block grant proposal; and surely, seniors will go without a true Medicare prescription drug benefit and possibly their choice of doctors or hospitals due to the President's Medicare reform proposal.

During this economic downturn, the President's budget is particularly cruel to the uninsured, poor and disabled that rely on Medicaid to help with health care costs. By block granting a large portion of the Medicaid program, the Bush administration simply passes the buck onto hard-pressed states. By shifting fiscal responsibility to states, the Bush proposal encourages states to limit their liability by capping enrollment, cutting benefits and increasing cost-sharing for millions of low-income people.

Mr. Chairman, $3.25 billion in 2004 and $12.7 billion over seven years is grossly inadequate when providing health care to our nation's most vulnerable populations. In addition, any short-term relief that states receive upfront under the block grant will have to be paid back at the end of the 10 year budget window. This is simply unacceptable. This proposal would not only harm Medicaid recipients, but also aggravate fiscal problems plaguing most states, including New Jersey, which would be forced to pick up the slack. We need to strengthen, not undermine, the Medicaid program by supporting an increase in the Federal Medicaid contribution (FMAP) that would provide a direct infusion of money to states this year and ensure health insurance for millions of low-income Americans.

I am also disappointed that the President rehashed his Medicare reform proposal and token prescription drug benefit program that does nothing to help millions of middle-income seniors who are now struggling to pay for their prescription drugs. In fact, it is painstakingly clear that the Bush administration wants to turn Medicare into a voucher program that will limit the government's responsibility while shifting costs to seniors. This "modernization'" proposal simply hands $400 billion to private plans—which is sure to end the Medicare program that seniors have depended on for over 35 years.

Furthermore, the Bush administration goes so far as to bribe seniors into managed care plans if they want to receive prescription drug coverage. Private plans throughout the nation have a terrible record of providing health services to seniors, and Mr. Chairman, the president should not be pressuring seniors to choose between badly needed drug coverage and the freedom to choose their own doctor and hospital under traditional Medicare.

The budget proposal of $400 billion over 10 years for Medicare reform is grossly inadequate when CBO has estimated that over the next 10 years, seniors will spend $1.8 trillion on drug costs. Seniors need a meaningful, real prescription drug benefit under Medicare—and seniors need to be able to choose their doctor and their hospital. We need to preserve the Medicare program and we need to ensure that our seniors have access to affordable and adequate health care.

We all know one of the best ways to ensure access specifically to affordable prescription medication is to allow generic drugs to enter the market. Although the FY 2004 budget includes a $13 million increase for the FDA Office of Generic Drugs, the administration's claim that this additional funding will speed up the process for bringing generic drugs to the market is false. In order for generic drugs to be available to consumers on a timely basis, the administration needs to support legislation that ends abuses by the brand name industry that block entry of generics on the market. Until legislation, such as S. 812 that passed in the Senate last year is signed into law, prescription drugs will remain unaffordable for seniors and the disabled.

I would also like to note that there are several gaps within the budget regarding Native American health issues that need to be addressed.

The President's budget proposes $3.2 billion in FY 2004 for IHS services. Of this amount, $150 million has already been appropriated for diabetes prevention and treatment, which leaves us with just over $3 billion. Of this amount, $560 million is "health insurance collections"—that is, reimbursements from Medicare, Medicaid, and private insurers. A majority of these reimbursements, in turn are from Medicaid. Yet, many of the states in which the IHS operates are facing severe revenue shortfalls and are likely to cutback on Medicaid eligibility, benefits, and provider payments. As a result, IHS and tribal providers in these states are likely to receive fewer Medicaid reimbursements than last year. Yet, the IHS budget projects appear to assume an increase in such collections. It is likely that the administration's projections are incorrect and that expected Medicaid collections will fall short of projections. My fear is that IHS and tribal providers will be forced to ration care to their patients, which comprise a very vulnerable population.

In addition, the American Indian population is projected to grow at about 1.5% per year for the next several years. At the same time, the consumer price index (CPI) for medical care is projected to rise at about 4% per year. In order to simply maintain the ability to provide services at current levels, the IHS and tribal providers will, at a minimum, need resources that increase at about 5.5% per year.

Unfortunately, your budget for Indian Health services, excluding not facilities, between FY 2004 and FY 2008 projects increases of about 2 percent per year (ranging from 1.7% to 2.4%), which represents only half of the necessary CPI. Over time, this really adds up. The difference between what you propose for IHS services in FY 2008—$2.875 billion—and what it would cost to maintain current services—$3.284 billion—is over $400 million in one year. This gap in funding is three times the amount of your allocation for the diabetes initiative alone.

IHS is currently underfunded and requires an increase of more than 5.5% per year. Instead, the administration is proposing to further underfund the IHS, and all traditional health programs.

Moving onto another topic, I would like to express my disappointment with the FDA's irresponsibility in the area of dietary supplements. Congress intended with the Dietary Supplement Health and Education Act to make a clear difference between fake, misleading, deceptive claims and legitimate claims. Getting to the heart of the matter, the FDA has been ineffective and inefficient in protecting the public. The FDA's actions and omissions to act, contribute to the myth that the dietary supplement industry is unregulated, and this agency only adds fuel to the recent controversy regarding the use of dietary supplements.

The FDA must stop doing a disservice to American consumers and must answer the industry's request for guidance by using its authority to regulate. If the FDA requires funding in order to carry out its responsibilities, then it is necessary for the FY 2004 budget to reflect adequate funding for the FDA to report and properly implement its Good Manufacturing Practices (GMP) regulations, which the industry has anxiously awaited for over 9 years.

In addition, I think it would be useful to provide funding for the FDA's Office of the Ombudsman to appoint a dietary supplement Ombudsman. This person would be responsible for facilitating suggestions from the industry and would be very helpful in providing guidance on many of the questions the industry is faced with today.

These topics barely scratch the surface of my concerns with the HHS portion of the FY 2004 budget. I look forward to the opportunity to discuss several additional topics with the Secretary during the question/answer period.

PREPARED STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Secretary, let me first extend my appreciation for coming before us today to discuss the President's budget. It seems like yesterday when you were here discussing the previous budget and we have yet to implement most of the initiatives you talked about last year. But we may get our act together and get that done in the next couple of days.

Mr. Secretary, I must say that there are some encouraging aspects of this budget blueprint but it is virtually impossible to praise any program while so much is in doubt for Medicare, Medicaid and other vital health programs that help so many people across the country. It is also difficult to determine the President's priorities.

The budget calls for a $169 million increase for Community Health Centers, like the Mount Vernon Neighborhood Health Center in my district, that will help many uninsured people get needed health care but the Medicaid and S-CHIP proposal appears to threaten the very existence of these critical programs by establishing a block grant with undefined benefits. It appears that the budget is like the kid in school who would pull the chair out from under his friend and then run over to help him up hoping to get praised for his kindness. There are other instances of this type of maneuvering. At a time when the Administration is pushing for malpractice reform it effectively cut funding to the Agency for Healthcare Research and Quality by $20 million over the last three years. AHRQ is the agency responsible for implementing patient safety initiatives. So again, it is difficult to determine the President's priorities. Pushing for malpractice reform while undermining patient safety programs is simply short-sighted.

This Committee appears to have the same short-sightedness. Last year we passed a good bill, the Patient Safety and Quality Improvement Act, and I was proud to be a cosponsor. But today we are scheduled to mark-up a bill that is stripped of important initiatives that would provide grants to hospitals to implement interoperability standards that promise to greatly reduce medical errors. I hope we can agree to improve upon this measure and pass a bill at least as strong as the bill we all supported just a few months ago.

Mr. Secretary, I thank you for your time and I look forward to your testimony and the opportunity to discuss aspects of the President's budget further.

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman, for holding this full committee hearing on the Administration's FY 2004 health care budget. It is always a pleasure to have Secretary Thompson before the committee, and I am certain we will enjoy a spirited discussion

about the Administration's FY 2004 budget for the Department of Health and Human Services (HHS).

HHS is the home to many of the critical programs that our constituents rely on, including the Medicare and Medicaid Programs, the Children's Health Insurance Program (CHIP), the National Institutes of Health (NIH), the Health Resources and Services Administration, and many other critical programs. I can safely say that the HHS budget directly impacts more Americans than any other federal government agency.

So it is with a heavy heart that I read the President's FY2004 health care priorities. Unfortunately, the President's funding levels for almost every program under HHS are woefully inadequate.

The Medicare program, which provides a critical health care safety net for almost 40 million seniors and individuals with disabilities, has been without a prescription drug benefit for far too long. Unfortunately, the President's budget includes only $400 billion for a prescription drug benefit, and this benefit is tied to requirements that seniors join private plans. This program builds on the Medicare+Choice program, and as we have learned with that program, it is unreliable and often leaves seniors without the coverage they need.

I am also disappointed in the President's Medicaid and CHIP budgets, which do not provide nearly enough assistance to the states. My home state of Texas is facing a $12 billion shortfall, and is in dire need of assistance for its Medicaid program. Instead of providing meaningful relief for the states through an increase in the Federal Medicaid Assistance Percentage (FMAP), the President put forth a vague and troubling measure that provides minimal short term assistance to the states, but puts them in the position of having to reduce services for current beneficiaries. This proposal would limit benefits for so-called "optional" recipients. But it fails to acknowledge that those beneficiaries are some of the most vulnerable within the Medicaid population—the elderly, children, and the disabled.

Furthermore, the Medicaid proposal fails to provide additional funds for what is sure to be an increase in enrollment. As the economy continues to falter, more and more Americans will be forced onto the Medicaid rolls. States need assistance for this crisis, and they need it now.

The President's CHIP program also fails to provide states with the assistance they need. States with unspent CHIP funds from FY98 to FY00—like Texas—had to return those funds to the U.S. Treasury. This has cost my home state $285 million. But instead of extending the availability of those funds to the states, the President is proposing only to allow states to keep only those funds that are set to revert to the Treasury at the end of FY 2003. The failure to reinstate those funds will put 790,000 children at risk of losing their CHIP coverage. Again, they need assistance and they need it now.

There are many other areas of troubling cuts and insufficient increases, including the budget for the NIH, which enjoyed 15 percent increases for the past five years, in keeping with the Congressional promise to double that budget. This year, they are given a paltry 2 percent increase—barely enough to keep up with inflation. The Community Access Program, which won Congressional authorization last year with almost unanimous support, has been zeroed out. The CDC's Chronic Disease budget is also woefully inadequate.

Mr. Chairman, the reality is that health care costs money, and that we have an obligation to spend our taxpayer's health care dollars wisely. These proposals are penny-wise and pound foolish, and will ultimately wind up costing us all in the long run.

Chairman TAUZIN. The Chair is now pleased to welcome our guest, The Honorable Tommy Thompson, the Secretary of the U.S. Department of Health and Human Services.

Mr. Secretary, at a moment in time when Americans, particularly those who live in this great city, are out at shopping malls buying necessary safety material for their homes and families because of the dire warnings of potential attacks upon this community, your presence is particularly important.

We welcome you and appreciate your comments not only about the agenda of your Department but of your own perspectives on the conditions facing this community at this moment. Mr. Secretary, we are pleased to welcome you.

And the Chair, by unanimous consent, will ask that the Secretary be given 10 minutes for his opening statements. Without objection, so ordered.

Mr. Thompson?

STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary THOMPSON. Mr. Chairman, Mr. Dingell, Mr. Waxman, Mr. Bilirakis, and all members of this wonderful committee, thank you so very much for giving me this opportunity to answer your questions as well as to testify this morning.

Mr. Chairman, I want to thank you personally for your continued leadership and friendship on so many issues that are vitally important to the American people. I have enjoyed our many meetings, and I know that all members of this committee want all Americans to be as healthy as they absolutely possibly can be. It is my passion. It is my motive for being here.

It is good to be with this committee again, and to have this opportunity to discuss the President's fiscal year 2004 budget for the Department of Health and Human Services. In my first 2 years at the Department, we have made tremendous progress in our efforts to improve the health, the safety, and the well being of the American people. We continue to make extraordinary advances, providing health care to lower income Americans, through waiver and State plan amendments granted to State governments for their SCHIP and Medicaid programs.

We have expanded access to health coverage through the waiver process to 2.2 million Americans, and we have expanded the range of benefits offered to 6.7 more million Americans through SCHIP and Medicaid through the waiver process in the last 2 years. And we have also brought up to date all of the waivers that were very much in delay when I came on as Secretary of this Department.

Last week I gave a waiver out for $1.8 billion to the State of California and the county of Los Angeles. Some of you were there, and even some of that money went to Stanford. Our progress is substantial, but it is far from being finished. So this year our work continues, as we propose new and innovative programs to promote the health and the well being of our fellow citizens.

The President's budget proposal contains $539 billion for HHS—an increase of $37 billion, or a 7.3 percent increase, which will enable the Department to continue to work to help improve the health and the safety of our Nation.

This proposal will fund programs to increase the Nation's readiness, to respond to potential bioterrorist attacks, bolster disease prevention efforts, cast a wider safety net to meet the critical health needs of the uninsured, and strengthen and improve Medicare and Medicaid.

Mr. Chairman, in light of recent events, I would first like to mention our efforts in the budget to fight bioterrorism. Our $3.6 billion bioterrorism budget would enhance the steps that we have taken since September 11, 2001.

And I would invite every member of this committee to stop over to the Department and see our new communication room. It is absolutely state-of-the-art.

If the request is approved, by the end of the next year we will have spent $9.2 billion to research, to prevent, and to prepare for a potential bioterrorist attack. This budget repeats last year's $1.45 billion investment in State, local, and hospital preparedness.

Since September 11, we have worked very closely with States of comprehensive public health preparedness and their response plans for chemical, biological, radiological, and nuclear attacks. And I am proud to say that as a Nation we are much better prepared for an attack of non-conventional weapons than ever before.

Am I satisfied? No. Are we making progress? Yes. And I would invite you once again to stop over and see how much progress we have made. I think it would allay a lot of the fears that you members might have.

In its address on the State of the Union, President Bush announced a brand-new initiative that was developed in the Department. It is called Project Bioshield, which will help prepare the country for bioterrorist attack by procuring effective countermeasures. We would spend roughly $6 billion—$6 billion over 10 years to speed up research and approval of vaccines and treatments and ensure a guaranteed funding source for their purchase once that research and completion has been done.

Project Bioshield would leverage the government's intelligence, the law enforcement, and the public health assets to enhance our preparedness. So while we are proud of the progress we have made over the past year, we are absolutely committed to become even better prepared against a larger number of potential threats in the next few years.

There has been much discussion and speculation in the media in recent weeks about the administration's plans to provide a drug benefit to Medicare beneficiaries. The administration's proposal to strengthen and improve Medicare is still being developed, and further details will become available in the next few weeks, and I will be more than happy to come back and explain them once all of the decisions have been decided.

But I can assure all the members on this side of the committee room that there is not going to be a force of seniors to go into HMOs in order to get drug coverage. But I can assure you that we are absolutely dedicated, passionate about, adding a prescription drug benefit to Medicare and enacting meaningful changes to strengthen, revitalize, and improve the program.

We have dedicated $400 billion over the next decade to achieve this ambitious goal, and we look forward to working very closely with this committee to develop and pass a responsible and effective Medicare bill this year.

Passing Medicare legislation is going to be a huge task as we all know, but it is necessary and this is the year, ladies and gentlemen, to do it. I pledge my support, and I pledge my cooperation to working with every member on this committee to accomplish that end result.

But there is other things that are just as urgent. In fact, Medicaid, which has been mentioned many times. Medicaid is growing even more rapidly than Medicare. The Federal portion is $285 billion, and the program grows at about 9 to 10 percent a year.

Like Medicare, Medicaid is absolutely vital to making sure that all Americans have access to health care. But State Medicaid programs are under tremendous financial pressure as all of us know, and beneficiaries risk losing coverage. Two-thirds of the States today have already made reductions or have reductions pending.

Under current law, the existing law, States are eliminating coverage of optional populations and dropping optional benefits. In the past year, 38 States have reduced services or eligibility, and most States are currently considering other benefit or eligibility cutbacks.

We want to give States another option. It is our responsibility to work together so that States get the help that they need in managing their health care budgets while preventing further service and benefit cuts and expanding coverage for low-income Americans.

Simply pouring more money into an outdated system will not bring that system up to date or repair its structural flaws. Failure to act will put the health insurance of thousands of Americans at risk, because States can no longer afford to maintain their current programs.

The President has also proposed a plan to preserve coverage and make Medicaid more efficient and provide better health care delivery. If Congress adopts this plan, States will be able to build on the successes of the wonderful State Children's Health Insurance Program, SCHIP.

And let me be very clear about two things. First, State participation in the new program would be optional. And, second, mandatory populations will continue to receive all of the mandatory benefits and all of the guarantees. And, third, this is not—this is not a block grant.

The Medicaid entitlement will be unchanged. States will have more flexibility in covering optional populations, which account for a large part of Medicaid spending. They will gain the ability to target special need populations, such as those suffering from mental illness and AIDS, and those who prefer home- and community-based care.

Somebody asked me if I am working with any Governors. I have addressed the NGA Executive Committee on a bipartisan basis. I have contacted no less than 30 Governors so far, and I will be meeting with the Governors on a bipartisan basis when they come to Washington in the next 2 weeks to meet at the NGA. And I have asked several Democrat Governors to set up a meeting, so I could go in and explain and work with them to develop a program.

We must begin by addressing the immediate fiscal needs of the States. President Bush's plan would meet the 9 percent base growth in the program, and then forward funding by $3.25 billion for 2004 and $12.7 billion over 7 years. And to be able to extrapolate that into what that would mean on the Federal match, it would be an increase of 2 percent. And a reduction of the cost for the States to go into the program would be another percent on the Federal match.

If we do not improve Medicaid, a million Americans could lose coverage this year and millions more next year. I look very much forward to working with you, Mr. Chairman, to make sure that they keep it.

Another issue of keen personal interest to me is the drastic toll that chronic diseases take on our society. Consider the following facts. A hundred million Americans are currently living with chronic diseases in America. Seven of every 10 deaths, more than 1.7 million every year, are caused by chronic diseases.

Our health care system waits for people to get sick and then spends billions of dollars to make them well. I want to do things differently, and I am sure you do as well. That is why our budget proposes a coordinated Department-wide effort to promote a healthier lifestyle by emphasizing the prevention of obesity, which costs $117 billion a year; diabetes, which costs $100 billion a year; asthma, and other risky youth behaviors. The HHS budget also includes an investment of $125 million for targeted disease prevention.

We continue, ladies and gentlemen, to implement our commitment to increase access to health care for Americans who have no health insurance. We are committed to providing new and expanded health centers in 1,200 communities, doubling the number of people served.

The fiscal year 2000 core budget expands the number of health centers by 120 to 3,698 centers, expand services in 110 existing sites, and would serve an additional 1.2 million people. And I thank the committee on a bipartisan basis for their support of this wonderful initiative.

Last year, we completed a 5-year doubling of a budget of the National Institutes of Health. This year we continue that commitment with a budget of $27.9 billion. It is a net increase of $549 million over last year. But because of the one-time projects that were funded in 2003, and not needed to be refinanced because we have built them and finished it, actual NIH research investment will rise by $1.9 billion, or a 7.5 percent increase.

The Bush Administration is also dedicated to combatting the spread of HIV and AIDS across the globe. The HHS budget contains $294 million in global AIDS, as well as $150 million for mother-to-child transmission of AIDS to children—things that I happen to be personally passionate about, and that is the reason I took over the chairmanship of the global fund.

I have got many more things to discuss, Mr. Chairman, but I realize that time is running short. Let me just suffice to say that it is an honor for me to be here. I am willing to answer your questions, willing to meet with any of you to discuss further issues as they come up, but this budget meets the needs of Americans at this point in time, and I thank you very much for giving me the opportunity to speak.

[The prepared statement of Hon. Tommy G. Thompson follows:]

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and members of the committee. I am honored to be here today to present to you the President's FY 2004 budget for the Department of Health and Human Services (HHS). I am certain you will find our budget exhibits a balanced proposal to improve the health and safety of our Nation.

The President's FY 2004 budget request continues to support the needs of the American people by increasing preparedness for terrorism, modernizing and strengthening Medicare, Medicaid, SCHIP; furthering the reach of the President's New Freedom Initiative; and, opening the doors of opportunity to all Americans.

The $539 billion proposed by the President for HHS will enable the Department to continue its important work with our partners at the State and local levels and the newly created Department of Homeland Security to secure our commitment to protecting our Nation and ensuring the health of all Americans. Many of our programs at HHS provide necessary services that contribute to the war on terrorism and provide us with a more secure future. I am particularly focused on: preparedness at the local level, ensuring the safety of food products, and research and development of vaccines and other therapies to counter potential bioterrorist attacks.

Our proposal includes a $37 billion increase over the FY 2003 budget, or about 7.3 percent. The discretionary portion of the HHS budget totals $65 billion in budget authority, which is an increase of $1.6 billion, or about 2.6 percent. HHS' mandatory outlays total $475.9 billion in this budget proposal, an increase of $32.3 billion, or roughly 6.8 percent.

Your committee will obviously be vital to achieving many of the Administration's most important priorities. I am grateful for the close partnership we have enjoyed in the past, and I look forward to working with you on an aggressive legislative agenda to advance the health and well being of millions of Americans. Today, I would like to highlight for you the key issues in the President's budget that fall under the Energy and Commerce Committee's jurisdiction.

SUPPORTING THE PRESIDENT'S DISEASE PREVENTION INITIATIVE

One of the most important issues on which we can work together is disease prevention. We all have heard the disturbing news about the prevalence of diabetes, obesity and asthma that could be prevented through very simple lifestyle changes. The statistics, I am sure, are as alarming to you as they are to me. The incidence of diabetes and obesity among Americans is up sharply in the past decade, putting millions more Americans at higher risk for heart disease, stroke and other related medical conditions.

Diabetes alone costs the nation nearly $100 billion each year in direct medical costs as well as indirect economic costs, including disability, missed work and premature death. Medical studies have shown that modest lifestyle changes—such as getting more exercise and losing weight—can reduce an individual's risks for developing these serious health conditions.

For this reason the HHS budget, consistent with the President's Healthier US effort, proposes a coordinated, Department-wide effort to promote a healthier lifestyle emphasizing prevention of obesity, diabetes, and asthma. The FY2004 budget includes a new investment of $100 million for targeted disease prevention.

STRENGTHENING AND IMPROVING MEDICARE

Through the leadership of Chairmen Tauzin and Bilirakis, the Energy and Commerce Committee has been at the forefront of efforts to strengthen and improve the Medicare program. As we are all aware, we need to fill the gaps in current Medicare coverage. This committee has dedicated countless hours to increasing public understanding of the challenges confronting the program, and your efforts have significantly advanced the debate over program modernization. While we remain steadfastly committed to ensuring that America's seniors and individuals with disabilities can keep their current, traditional Medicare, the President has proposed numerous principles for Medicare enhancements to ensure that we are providing beneficiaries with the best possible care. The budget builds on those principles by dedicating $400 billion over ten years to strengthen and improve Medicare, including providing access to subsidized prescription drug coverage, better private options and better insurance protection through a modernized fee-for-service program.

Prescription Drug Coverage

Ensuring that Medicare beneficiaries have access to needed prescription drugs is a top priority for the President and me. This budget proposes a prescription drug benefit that would be available to all beneficiaries, protect them against high drug expenditures, and would provide additional assistance to low-income beneficiaries through generous subsidies to ensure ready access to needed drugs. The Administration's prescription drug plan would offer beneficiaries a choice of plans and would support the continuation of the coverage that many beneficiaries currently receive through employer-sponsored and other private health insurance.

Medicare Choices

Medicare+Choice was introduced to provide beneficiaries with options in their health coverage. Over the past year, the Department has made significant strides in expanding beneficiaries' Medicare+Choice options by approving 33 new preferred provider organization through a demonstration. However, due to a variety of factors,

in many parts of the country, few new plans have entered the program. More needs to be done to encourage plan participation in this important program. This Administration believes that Medicare+Choice payments need to be linked to the actual cost of providing care. America's seniors should have access to the same kind of reliable health care options as other citizens. We believe that we should move away from administered pricing to set Medicare+Choice rates and that those choices should be provided through a market-based system in which private plans compete to provide coverage for beneficiaries. Those beneficiaries who select less costly options should be able to keep most of the savings. It is time we give our seniors the choice they have been promised in Medicare.

Modernized Fee-for-Service

One of the basic tenets of our reform proposal is that seniors deserve the same range of health care delivery choices as federal employees enjoy. These choices should reflect the benefit innovations incorporated into private sector plans. The Administration is very interested in updating Medicare to reflect the insurance protections offered in the private sector. This system should modify and rationalize cost-sharing for beneficiaries who need acute care. A modernized Medicare should eliminate cost sharing for preventive benefits and provide catastrophic coverage to protect beneficiaries against the high costs caused by serious illnesses.

STRENGTHENING AND IMPROVING MEDICAID

State Health Care Partnership Allotments

Chairman Tauzin, as you know, states are confronting serious challenges in running their Medicaid programs. It is crucial that we do something now to stabilize Medicaid programs so we do not allow millions of Americans to go without health care. Under current law, states have every right to eliminate coverage of optional populations and to drop optional benefits. They are doing so. In the past year, 38 states have reduced services or eligibility and most states are currently considering other benefit or eligibility cutbacks. We want to give states another option. It is our responsibility to work together so that States can get the help they need in managing their health care budgets, while preventing further service and benefit cuts and expanding coverage for low income Americans.

Building on the success of the State Children's Health Insurance Program (SCHIP) and the Health Insurance Flexibility and Accountability (HIFA) demonstrations in increasing coverage while providing flexibility and reducing the administrative burden on States, the Administration proposes optional State Health Care Partnership Allotments to help States preserve coverage. Under this proposal, States would have the option of electing to continue the current Medicaid program or to choose partnership allotments. The allotment option provides States an estimated $12.7 billion in extra funding over seven (7) years over the expected growth rate in the current Medicaid and SCHIP budgets. If a State elects the allotments, the federal portion of the SCHIP and Medicaid funding would be combined and states would receive two individual allotments: one for long-term care and one for acute care. States would be required to maintain their current levels of spending on Medicaid and SCHIP, but at a lower rate of increase than current law.

States electing a partnership allotment would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the increased flexibility of these allotments will allow each State to innovatively tailor its provision of health benefit packages for its low-income residents. For example, States could provide premium assistance to help families buy employer-based insurance. States could create innovative service delivery models for special needs populations including persons with HIV/AIDS, the mentally ill, and persons with chronic conditions without having to apply for a waiver. Another important part of the new plan would permit States to encourage the use of home and community based care without needing a waiver, thereby preventing or delaying inappropriate institutional care. Let me stress that this is an OPTION we are proposing for States.

New Freedom Initiative

Home and community-based care as an alternative to nursing homes for the elderly and disabled is a priority of this Administration. The New Freedom initiative represents part of the Administration's effort to make it easier for Americans with disabilities to be more fully integrated into their communities. Under this initiative, we are committed to promoting the use of at-home and community-based care as an alternative to nursing homes.

It has been shown time and again that home care combines cost effective benefits with increased independence and quality of life for recipients. Because of this, we

have proposed that the FY 2004 budget support a five-year demonstration called "Money Follows the Individual" Rebalancing Demonstration, in which the Federal Government will fully reimburse States for one year of Medicaid home and community "based services for individuals who move from institutions into home and community-based care. After this initial year, States will be responsible for matching payments at their usual Medicaid matching rate. The Administration will invest $350 million in FY 2004, and $1.75 billion over 5 years on this important initiative to help seniors and disabled Americans live in the setting that best supports their needs.

The Administration again proposes four demonstration projects as part of the President's New Freedom Initiative. Each promotes home and community-based care as an alternative to institutionalization. Two of the demonstrations are to provide respite services to caregivers of disabled adults and severely disabled children. The third demonstration will offer home and community-based services for children currently residing in psychiatric facilities. The fourth demonstration will test methods to address shortages of community direct care workers.

Medicaid Coverage for Spouses of Disabled Individuals

The Budget proposes to give States the option to extend Medicaid coverage for spouses of disabled individuals who return to work and are themselves eligible for supplemental security benefits. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to the spouse the same Medicaid coverage protection this Committee was instrumental in offering to the disabled worker.

Extension of the QI-1 Program

Under current law, Medicaid programs pay Medicare Part B Premiums for qualifying individuals (QI-1s), who are defined as Medicare beneficiaries with incomes of 120% to 135% of poverty and minimal assets. This program was set to expire on December 31, 2002 but it is being extended under a series of continuing resolutions. The Budget would continue this premium assistance for five years.

Transitional Medicaid Assistance (TMA)

TMA provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare related Medicaid eligibility due to earnings from work, and was scheduled to sunset in September 2002. It has been extended through a series of continuing resolutions. This budget proposal would extend TMA for five more years, costing $400 million in FY2004, and $2.4 billion over five years. This program is an important factor in establishing independence for former welfare recipients by providing health care they could not otherwise afford.

We are also proposing modifications to TMA provisions to simplify it and make it work better with private insurance. These provisions include:

- States will be given options to offer 12 months of continuous care to eligible participants.
- States may waive income-reporting requirements for beneficiaries.
- States that have Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements.
- States have the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits.

State Children's Health Insurance Program (SCHIP)

As you know, SCHIP was set up with a funding mechanism that required States to spend their allotments within a three-year window after which any unused funds would be redistributed among States that had spent all of their allotted funds. These redistributed funds would be available for one additional year, after which any unused funds would be returned to the Treasury. An estimated $830 million in FY 2000 funds are expected to go back to the Treasury at the end of FY2003. The Administration proposes that States be permitted to spend redistributed FY2000 funds through the end of FY2004. Extending the availability of SCHIP allotments would allow states to continue coverage for children who are currently enrolled and continue expanding coverage through HIFA waivers.

Medicaid Drug Rebate

Over the past year it has become evident that the best price component of the rebate can be confusing, as it is not always clear which prices a manufacturer must include when calculating and reporting to CMS its best price. In addition, best price may serve to limit the discounts that private sector purchasers are able to negotiate

with pharmaceutical manufacturers. The Administration is interested working with this Committee and the Senate Finance Committee to explore policy options in this area that would improve the Medicaid drug pricing and reimbursement system and generate program savings. The current methodology sets rebates equal to the difference between a drug's average manufacturer's price (AMP) and the manufacturer's best price for that medication.

FIGHTING BIOTERRORISM

As Americans confront the realities of terrorism and hatred around us, it is imperative that the Federal Government be prepared to keep our citizens safe and healthy. HHS's $3.6 billion bioterrorism budget proposal substantially expands ongoing medical research, maintains State and local preparedness funding, and includes targeted investments to protect our food supply. The President's proposal significantly expands NIH research funding needed to develop vaccines and medicines that will make biologic agents much less effective as weapons. HHS will continue to manage the Strategic National Stockpile, funded by DHS, and also provide the scientific and public health direction needed to ensure that the pharmaceutical stockpiles include proper amounts of effective drugs , vaccines, other biologics, certain emergency medical equipment, and associated material.

HHS and the Department of Homeland Security will spearhead the development of Project Bioshield. This project, which the President just announced, will bring together the resources of the United States government in an innovative effort to develop defenses against bioterror before they are ever needed. Project Bioshield will have three (3) major goals:

- Ensure sufficient resources are available to procure the next-generation countermeasures. A guaranteed funding source must be available to enable the government to purchase vaccines and other therapies as soon as experts believe they can be made safe and effective, and spur the industry investment needed to produce them.
- Speed up NIH research and advanced development, providing more flexible contracting and procurement authorities for critical biodefense work.
- Make promising treatments available more quickly for use in emergencies by establishing a new FDA Emergency Use Authorization for promising medical countermeasures that are under development. This provides greater flexibility in emergency situations than the current Investigational New Drug (IND) authority.

Funding for this work will be in the new Department of Homeland Security (DHS) which will make determinations about what countermeasures may be needed based on threat assessments. HHS will provide the scientific direction, and carry out the actual procurements.

IMPROVING THE NATION'S HEALTH

In an effort to improve the Nation's health, the budget includes initiatives to reduce drug-related medical costs and carry out the Best Pharmaceuticals for Children Act. The request for the Food and Drug Administration (FDA) includes $13 million to increase Americans' access to safe, effective, and less expensive generic drugs. The budget also includes an additional $30 million in NIH and FDA funding to expand Federal and private research to improve information for prescribing pharmaceuticals to children.

The HHS budget includes a series of improvements in the financing of childhood vaccines to meet three goals—improve vaccine access, restore tetanus and diphtheria toxoid vaccines (Td, DT) to the Vaccine for Children (VFC) program, and build a national stockpile of childhood vaccine. To ensure against future shortages, HHS will use its current authority to begin building a vendor-managed, 6-month supply of all childhood vaccines by 2006. In addition, legislation will be proposed to improve access to VFC vaccines for children already entitled to them. The budget proposes to expand the number of access points for underinsured children—those whose private insurance does not cover the immunizations—by allowing them to receive their VFC vaccines at State and local public health clinics. The Administration also proposes to restore tetanus-diphtheria booster to the VFC program. The VFC caps prices for the few remaining vaccines that were in use prior to 1993, but the price caps are so low that tetanus-diphtheria booster was removed from the VFC program in 1998 when no vendor would bid on the contract.

The budget also contains $100 million to begin working with industry to ensure the nation has an adequate and a timely supply of influenza vaccine in the event of a pandemic. We cannot stockpile influenza vaccine, and current manufacturing methods could not surge to meet the Nation's needs in a pandemic. Funds will be

used for activities to ensure a year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies.

In FY 2003, we are completing a 5-year doubling of the budget of the National Institutes of Health (NIH). This year, we continue that commitment with a budget of $27.9 billion, a net increase of $550 million over last year. As a result of one-time projects being funded in fiscal year 2003, and not needing to be re-financed, actual NIH research will increase by $1.9 billion, or 7.5%, and will fund a record number of new and competing research grants.

We are investing $50 million in a new program at AHRQ to increase investments in information technology in hospitals that will improve patient safety. Of this amount, $26 million will be used to focus on small and rural hospitals. Proven technologies like computerized physician order entry and automated medication dispensing systems improve the safety and quality of care.

We must do everything within our abilities to address the disparities in health care in this Nation. The FY2004 budget proposes numerous activities to move away from such inequities.

- The budget continues the third year of the President's Health Center Initiative with a total of $1.6 billion, an increase of $169 million, to provide health care services to nearly 14 million individuals. In support of the Health Center Initiative, the President is also seeking to expand the National Health Service Corps to increase the number of health care providers in rural and underserved areas. Additionally, the Budget will increase efforts to recruit underrepresented minorities for participation in the program and better serve minority populations.
- The budget also proposes a $10 million increase for the breast and cervical cancer program through the Centers for Disease Control and Prevention, which supports screenings for low-income, underinsured, and uninsured women between the ages of 50-64.
- The Ryan White AIDS Drug Assistance Program will receive an increase of $100 million or 16 percent to purchase medications for an additional 9,000 persons living with HIV/AIDS, for a total of nearly 100,000 clients during the fiscal year.
- Indian Health Services will receive an increase of $73 million, including $20 million to provide sanitation facilities to over 22,000 American Indian Homes and $25 million to improve health care not available through IHS or tribal providers.

FAITH BASED AND COMMUNITY INITIATIVES

In support of the President's Faith-Based and Community Initiative, the HHS FY2004 budget supports programs that promote positive relationships that link faith- and community-based organizations, State and local governments, and Federal partners to develop a shared picture for substance abuse treatment and positive youth development.

We are proposing to establish a new $200 million drug treatment program. For some individuals, recovery is best assured when it is achieved in a program that recognizes the power of spiritual resources in transforming lives. Under this new program, individuals with a drug or alcohol problem who lack the private resources for treatment will be given a voucher that they can redeem for drug treatment services. The program will give them the ability to choose among a range of effective treatment options, including faith-based and community-based treatment facilities. Another important program that helps some of our most vulnerable children is the Mentoring Children of Prisoners program. We are asking for funds to be increased to $50 million, which would in turn be made available to faith-based community-based, and public organizations for programs that provide supportive one-on-one relationships with caring adults to these children who are more likely to succumb to substance abuse, gang activity, early childbearing and delinquency. In addition, the budget request for the Compassionate Capital Fund is $100 million, the same amount requested in FY2003, and an increase of $70 million over the FY2002 appropriation. These funds would continue to be used to support the efforts of charitable organizations in expanding model social service programs. The Fund would also continue to provide technical assistance to faith- and community-based organizations to expand and enhance their services. These are just a few examples of the services that can be provided to those in need under this initiative.

PRESIDENT'S MANAGEMENT AGENDA

I am committed to improving the management of the Department of Health and Human Services, and I realize that as we work to improve the health and well-being of every American citizen, we also need to improve ourselves. The FY2004 budget

supports the President's Management Agenda and includes cost savings from consolidating administrative functions; organizational delayering to speed decision making processes; competitive sourcing; implementation of effective workforce planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations. We have also included savings in information technology (IT) which will be realized from ongoing IT consolidation efforts and spending reductions made possible through the streamlining or elimination of lower priority projects. I am also very excited about the IT infrastructure consolidation which should be fully implemented by October, 2003, that will further reduce infrastructure expenditures for several HHS agencies.

IMPROVING THE HEALTH AND SAFETY OF OUR NATION

Mr. Chairman, the budget I bring before you today contains many different elements of a single proposal; what binds these fundamental elements together is the desire to improve the lives of the American people. All of our proposals, from building upon the successes of welfare reform to protecting the nation against bioterrorism; from increasing access to health care, to strengthening Medicare, all these proposals are put forward with the simple goal of ensuring a safe and healthy America. I know this is a goal we all share, and with your support, we are committed to achieving it.

Chairman TAUZIN. The Chair thanks the gentleman. Indeed, the Chair recognizes himself for a round of questions, and members in order.

Mr. Secretary, first of all, as you know, our committee shares jurisdiction with the Ways and Means Committee in producing the Medicare Modernization Act that we will jointly work on with your Department and the White House over the next several months.

And you have again our commitment, as we gave it to you last Congress, to complete that work through the House in a timely fashion, so that we can this year get it through the Senate and hopefully get a prescription drug benefit bill signed into law that provides this essential service for our seniors and modernizes Medicare at the same time.

But Medicaid is specifically and exclusively within the jurisdiction of the Energy and Commerce Committee. And so it is on our watch that we watch States cutting back on their programs because of dire shortages of funds and program expansions, in terms of costs that they can't keep up with.

And reforming Medicaid has to be one of our main functions this year, and I challenge the committee, both Democrats and Republicans, to come together as soon as we possibly can, because this is our committee's exclusive responsibility.

And I look forward to going over in more detail your recommendations, including those which, by the way, I think are borrowed, if I understand your recommendations correctly, from your own experience as Governor, where your State had to request waivers for increased flexibilities in your program, and where having been granted those waivers your State made some significant savings in its Medicare program and Medicaid program, and at the same time increased dramatically the reach of the program to serve the highest needs within your State.

That is essentially what you want to do nationwide is to create more of that same flexibility over the next 10-year period. Is that correct?

Secretary THOMPSON. That is absolutely correct. In fact, Mr. Chairman, quickly, I set up a program called Badger Care, which has been proclaimed as one of the finest initiatives to help low-in-

come families get health insurance. I also started a program under a waiver program for the disabled community to be able to keep their medical coverage while they went to work before the Congress acted. And I also developed a program to keep individuals in their own homes without going to institutions.

Chairman TAUZIN. In fact, much of your recommendations, as I read them coming to us, are designed to create those new freedoms, where the money follows the individual out of an institution, back into the community, back into the homes. Is that correct?

Secretary THOMPSON. That is the genesis of the program, and the real reason that the program is here is to give the States the flexibility to be innovative, to cover more people, and not cut them off.

Chairman TAUZIN. Mr. Secretary, I look forward again to engaging you on this critical issue, because, again, our committee must complete this work this year.

At this moment, however, I think most Americans, particularly those around this community and other major cities of our country, are most concerned about the warnings that your Department and the Homeland Security Department and our intelligence agencies have recently given to Americans. And those warnings seem to center around the potential threat of either a chemical, biological, or perhaps a radiological attack upon communities such as this great community in Washington, DC.

Families are being advised to buy certain stocks of water, tape, plastic, to seal their windows and doors, in order to survive for 3 days in the event of such an attack. Members are calling me to ask me what I know, what more do I know about what we might face, and what they ought to tell their families and their children.

Can you elaborate at all on this threat, these advices, and what is prudent for families in this community and other cities who face this threat to be considering as we complete the Hajj, and we are in this period of potential conflict in Iraq?

Secretary THOMPSON. Mr. Chairman, I would much rather go into executive session if you want to get into specific details. But let me just——

Chairman TAUZIN. Again, I am not asking you to do that. I am asking you just to help, in a general way, explain to American families what is happening right now, and why these warnings are as specific as they are, and what—why, indeed, are they being asked to purchase and acquire these specific items as we read about in the press.

Secretary THOMPSON. First off, the question about purchasing those supplies should be directed to Homeland Security and Tom Ridge, but let me tell you from my perspective in regards to being responsible for biological, radiological, and nuclear preparations.

We are very prepared to respond, but the truth of the matter is is that anybody that wants to commit suicide or submit or emit any kind of aerosolized biological toxins, it is very easy to do, and we have to be able to be able to quickly respond. And that is what we have set up at the Department of Health and Human Services.

In fact, we have activated a couple of our medical assistant teams today, and we have put on alert a few more. The reason being is that it is ending up at the Hajj, and we have seen an in-

crease of threats from the Middle East and across the world that are directed at Europe and at the United States.

And so in order to be prepared, in order to quickly respond, you have to put people in place as well as equipment and medical supplies, which we have done, because if it is a biological, we have a little time to respond, but if it is chemical you have to get the anecdotes into the individual very quickly, within hours. And so we have got to put people on alert, just in case something might happen.

But in regards to the overall threats, they have increased, and we are concerned about them. And that is why we are—that is why we level—or increased the level up to orange, as well as getting better prepared and more people on alert.

Chairman TAUZIN. And Americans should heed these warnings seriously.

Secretary THOMPSON. They should heed the warnings. They should not disrupt their plans, but they should be very vigilant in their everyday life and business.

Chairman TAUZIN. Thank you.

The Chair recognizes the gentleman Mr. Waxman for 8 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman, and, Mr. Secretary, welcome to the committee. I want to ask you about Medicare and Medicaid, but just briefly I don't think that the small pox vaccination program is as effective as we would like it to be because of the lack of compensation for those who are being immunized.

I intend to introduce a bill tomorrow with several of my colleagues here on the committee in an attempt to get a dialog going. I hope you will consider it and take it in the spirit in which it is offered, and I want to assure you we want to work with the administration.

I assume you believe that if someone is risking their own health and the health of their family and patients by volunteering to be vaccinated, they deserve to be compensated in case they are injured by the vaccine.

Secretary THOMPSON. Congressman, you are absolutely correct, and that is why we are working on a proposal. In fact, we should have one up to the Congress hopefully by the end of this week.

Mr. WAXMAN. Very good. Well, we will look forward to working with you on that.

Secretary THOMPSON. And I thank you for your support, and I thank you for your interest in this thing. And it is absolutely imperative that we get more people vaccinated for small pox in order to be better prepared. And I thank you for your interest in this subject.

Mr. WAXMAN. Thank you. Mr. Secretary, I want to talk about Medicaid first.

Secretary THOMPSON. Okay.

Mr. WAXMAN. The administration's proposal is a very radical departure from Medicaid as we have known it, which has been a program which is an entitlement. And the administration is proposing to make this a block grant. You say it is not a block grant, but if there is a cap on the Federal funds, which means that they don't increase when there are more people who need services, or the costs of those services increase, if there are few requirements on

how the program is run, and there are no enforceable rights, that is the earmark of a block grant.

Now, I think we have a disagreement.

Secretary THOMPSON. Congressman, but I——

Mr. WAXMAN. No, I want to ask you specifically about that. I think we have a disagreement about this. I don't think this is a sound idea. I know the administration said that there are mandatory populations that are going to be protected, but there are a lot of populations under Medicaid that are not considered mandatory—people in nursing homes, disabled people who are trying to hold down a job, kids in families with incomes slightly above poverty, women whose breast cancer was found through public health screening programs. All of these people are somehow less deserving of protections because they are not in the mandatory groups. I think that is really offensive and certainly troubling.

Now, the question is, what kind of flexibility are we going to give to the States? Because if we give the States a lot of flexibility, less money but more flexibility, then we are not going to have guarantees to rights of care. And if we are giving Federal dollars to the States to run their Medicaid programs, it seems to me we ought to have certain basic rules for every American, no matter what State they live in, to be assured of certain protections.

So I would like to ask you, would nursing home standards for safety and appropriate care continue to apply in every State that is under Medicaid, whether they are in the block grant or not?

Secretary THOMPSON. In order to answer that question, I have to correct a couple of things that you said, Congressman. And, first, and all due respect to you, I know how interested and passionate you are on this subject, as I am. First off, this is not a block grant. The money will continue to rise at a 9-percent increase each and every year.

No. 2, the mandatory population is not going to be capped, as you indicated. It is not. Third, State—the optional population is approximately one-third of the population in Medicaid. The two-thirds will continue to get the mandatory coverage as they currently exist, the same guarantees, and no changes.

Mr. WAXMAN. Mr. Secretary, I am going to have to interrupt you, because I know you are going to say that you think this is not a block grant. But if there is a mandatory population and they get—the State gets a certain amount of money, even if it is increasing, it is capped, it is limited, and that means that the States have to come up with their own money to deal with these matters. That is called a conditional block grant.

But let me ask you specifically, in your proposal, will there still be protections for nursing home standards for safety and appropriate care that——

Secretary THOMPSON. Yes.

Mr. WAXMAN. [continuing] we have at the Federal level?

Secretary THOMPSON. Yes, there will.

Mr. WAXMAN. It will apply to every State?

Secretary THOMPSON. If it is optional, the States right now can change it, Congressman.

Mr. WAXMAN. No, no. There are Federal laws——

Secretary THOMPSON. And the Federal laws—the Federal law stays. We don't change that. It is on the optional population, and the optional services, which consists of two-thirds of the budget.

Mr. WAXMAN. Well, let us don't get too complicated, because most people in nursing homes are optional. They are not mandatory. But whether it is optional or mandatory——

Secretary THOMPSON. But the standards state——

Mr. WAXMAN. But Federal law requires that we have nursing home standards. Now I would like to ask you——

Secretary THOMPSON. It is standard, Congressman——

Mr. WAXMAN. Okay. I would like to ask you whether the protections against spousal impoverishment, which means that the husband or wife of a person who goes in a nursing home, will be assured they will have money to live on, will those provisions continue to apply? Will the States be required under Federal law——

Secretary THOMPSON. They will, Congressman.

Mr. WAXMAN. Okay.

Secretary THOMPSON. It is the optional services for the optional population that States now, under the existing law, can change—the States will have the flexibility. Instead of having uniform coverage throughout those, the States will have the opportunity to determine, under the optional population, if they want to cover them, the same way they have right now.

Mr. WAXMAN. Well, excuse me, Mr. Secretary. My question is not whether they can cover them or not, or it is optional or not. Will nursing home patients have guaranteed care to meet Federal standards?

Secretary THOMPSON. Yes.

Mr. WAXMAN. Will their spouses be protected from being impoverished under the Federal law as it is now in the Medicaid program?

Secretary THOMPSON. Yes.

Mr. WAXMAN. Okay.

Secretary THOMPSON. And it——

Mr. WAXMAN. My next question would be, would people in managed care plans have the right to go to emergency rooms if they were in a situation where any prudent layperson would recognize that emergency care was necessary? There was some flirting of the idea of changing that. The administration pulled back. But would all States be required to provide this emergency care? Would they have flexibility to deny it?

Secretary THOMPSON. They will have—if it is for the optional population, if it is the optional population, unless it is a State or Federal law, they will have the option to cover that, the same way the existing law does. No difference——

Mr. WAXMAN. Well, if they have the option to——

Secretary THOMPSON. [continuing] they can——

Mr. WAXMAN. [continuing] have the option not to cover it.

Secretary THOMPSON. The Medicaid——

Mr. WAXMAN. Isn't that correct?

Secretary THOMPSON. That is correct, but that is the existing law, Congressman.

Mr. WAXMAN. I don't believe it is.

Secretary THOMPSON. Yes, it is.

Mr. WAXMAN. Because a Medicaid beneficiary can go to court, and if their care is being rationed by anybody, they can go and get an enforceable right. Would they still have that——

Secretary THOMPSON. Yes, they will.

Mr. WAXMAN. [continuing] if they are optional?

Secretary THOMPSON. Yes, they will. It is the optional services that the States currently have, Congressman. The States right now have the authority under law to stop it. We are not changing that. What we are asking for you to do, and for the Congress to do, is to allow them to develop a more comprehensive program to cover these people, and get an advance funding and less money paid in.

Mr. WAXMAN. Mr. Secretary, at your press conference you were asked how much flexibility the States will have, and you said, "Carte blanche in the optional populations they have right now." When asked if there would be any limits at all for the optional benefits and populations, you said "complete flexibility."

Secretary THOMPSON. That is what they have now.

Mr. WAXMAN. Well, I don't believe that is what they have now, but I do believe that that is what the administration is proposing, and the States are being coerced into accepting a block grant limited Federal funds, increasing it first but then decreasing later on in order to get the Federal Government out of the business of assuring health care for some of our most vulnerable people.

Secretary THOMPSON. But, Congressman, they have the option right now to stop it. States do. They do. And they have the flexibility to——

Mr. WAXMAN. If you are in the program——

Secretary THOMPSON. [continuing] the optional benefits——

Mr. WAXMAN. If you are in the program under Medicaid now, everywhere in America the States must provide the standard of care, the level of care. It is an entitlement.

Chairman TAUZIN. The gentleman's time has expired.

Mr. WAXMAN. If the Secretary may answer.

Secretary THOMPSON. Congressman Waxman, they will continue.

Chairman TAUZIN. The Chair now recognizes——

Secretary THOMPSON. It is a Federal law. They will continue to have it—mandatory—we are given the flexibility, the same right they have under the existing law to change the optional population, but more flexibility in funding and more opportunity to be able to give coverage to those people.

Chairman TAUZIN. The Chair now recognizes the gentleman from Florida, the chairman of the Health Subcommittee, for 8 minutes.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman.

Mr. Secretary, as you may know, I have always been a big fan of the community health center concept. I know that was brought up by——

Secretary THOMPSON. I thank you for it.

Mr. BILIRAKIS. [continuing] one of our members in his opening statement. It is a vital safety net for so very many Americans.

Now, the budget calls for a $169 million increase for those health centers. We are pleased with that. But I would ask you, sir, if you can, give us an idea about what levels of funding you think would be necessary in the following years to help with expanding commu-

nity health centers—you know, maybe not exact dollars figures but percentages or something toward that end.

Secretary THOMPSON. We have—the Congress and the administration have always added additional money in the last 2 years in the neighborhood of $150 to $185 million. And we have been able to grow at approximately 230 to 250 community health centers across America. And I thank you for your passion on this, Congressman, and I think it is in that area—if we keep growing at that rate, we are going to be in good shape across America.

This is something the President and I are very passionate about. It is something that really meets the needs of the uninsured and those individuals that need coverage, and it is usually very good coverage.

Mr. BILIRAKIS. Yes, sir. And I have seen that firsthand. And, certainly, it is not the full answer to the uninsured, not the complete answer, but it certainly goes a long way toward that end. And that is why I have always felt this way—and Mr. Waxman knows this, because we have held hearings together on that subject over the years.

Mr. Secretary, unless the plans have changed, after this hearing we plan to go into a markup on the Patient Safety and Quality Improvement Act. And I know that, as you know, this committee has been active in the area of reducing medical errors.

I wonder if you can tell us what will the AHRQ budget request includes in the area of patient safety.

Secretary THOMPSON. We have added a lot of money in it, because it is one of our interests. There is going to be an increase of $30 million, Congressman, and it is for reducing medical errors and improving patient safety.

We are also doing something in the Department. We are standardizing the codes for technology, which is going to make it easier to have uniform technology in the health care delivery system, and we are also requesting an administrative rule to bar code all of the drugs so that the drugs will be bar coded, which will be easier to use the swipe capacity to improve the safety of all patients.

And we are making lots of progress in this area, plus we have improved the quality assurances in nursing homes and in hospitals now.

Mr. BILIRAKIS. The patient safety organizations that we envision in our legislation, the new entities if you will, you have contemplated that as far as your budgeting is concerned.

Secretary THOMPSON. Yes, we have, and I thank you for the legislation. It is very good legislation. I only wish that I could convince Members of Congress and this committee to take some of the fraud and abuse money that we get and put it into a mini-Chairman Tauzin committee, so that we could get uniform technology across America and put $1 in for—or a $3 match for every $1 we have in it. It would be an excellent initiative.

Mr. BILIRAKIS. There we go. That is a challenge to you, Mr. Chairman.

Mr. Secretary, long-term care—we know that we are going to be facing a tidal wave as the baby-boomers begin to need long-term care. They are going to likely redefine how we deliver long-term care in this country, and we do need—I mean, there are so many

needs out there. We are not concentrating on prescription drugs, if you will, but we also know that there is no coverage for long-term care in Medicare.

So I would ask you—you know, our current programs, both Medicare and Medicaid, just don't have the capacity to handle these populations, particularly as they are going to be coming down the line. So what steps does the budget take? And if we can expand maybe past that, how do you and the administration see the preparations for future demands on our long-term care system?

Obviously, you know I come from a very elderly district in Florida. And it is a concern there, but it is a concern everywhere in the entire country.

Secretary THOMPSON. The Medicaid proposal is—we are requesting the States that voluntarily go into the new Medicaid program to split the Medicaid into acute care and long-term care, because the long-term care is the one that is growing the most rapidly.

And what we are trying to do is give the States the flexibility in the long-term care, which I did back in Wisconsin, is to be able to allow the long-term care to take the money and use it to purchase their services and stay in their home, much more so than going into an institution and nursing home.

And we think that that is a giant step forward. We have also—the President has put in $220 million over 5 years with $11 million proposed for fiscal year 2004, and that is the new Freedom Initiative to help individuals that are disabled to be able to also stay in their own home. And so these are two strong proponents. They are two strong pieces to address that particular question.

The Medicare thing, we want to also look at a stop-gap loss in Medicare, which we think is very important. It has not been in there before, and we think that also needs to be in the new streamlined, refined, improved, innovative Medicare system.

Mr. BILIRAKIS. Well, I am sure we all agree that that certainly is not adequate in terms of the current as well as the expected long-term care needs of our country.

You finished up your answer with the point on the Medicare and stop-loss if you will. And others have said this, Mr. Chairman. The administration does not have a definitized black and white plan on Medicare. Is that not true?

Secretary THOMPSON. That is absolutely——

Mr. BILIRAKIS. And prescription drugs in Medicare modernization, I mean, you have committed to working with the Congress on this, so that there aren't really any preconceived—I guess there is some thinking out there, obviously, principles if you will, but no preconceived black and white definitized plans on it. Is that—isn't that correct? And we are working together on this.

Secretary THOMPSON. That is correct, Congressman. The final decisions have not been made. We are working very hard on it, and hopefully we will complete our work relatively soon, so we can share that with you and other members of this committee, as well as other Members of the Congress.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Secretary. I yield back.

Chairman TAUZIN. The Chair thanks the gentleman.

The Chair recognizes for 8 minutes the gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

Secretary, there is an issue that Senator Dole and I share a great concern about, and it is the issue of what happens to someone who has been certified by a physician to be seriously and permanently unable to take care of themselves, Parkinson's, ALS, later stages of these diseases, and who qualify for home care service under Medicare.

What happens to them if they leave the home in a car for a ride with their spouse, or to be walked around the neighborhood? Under existing law, even after people have been diagnosed and certified by physicians to have this problem, the individual would lose any further visitations for a home health care benefit.

Now, there is a man, a very courageous man. His name is David Jane, and he approached Senator Dole and I on this issue. He has ALS. He cannot breathe on his own. He cannot move on his own. But he was asked if he wanted, with his other fellow alumni of the University of Georgia, to be taken to an alumni weekend football game at the University of Georgia.

He did so. It was written up in The Atlanta Constitution. And then, his home health agency saw it and removed any further visitations to his home, even though he cannot take care of himself at all.

And so last year Susan Collins and I, over in the Senate, we introduced a bill to basically say that it is common sense that once—no one is going to try to have themselves diagnosed with Alzheimer's or Parkinson's or ALS, or any other chronic disease, in order to qualify for home health care visits.

And we contend that there is going to be no increase in the costs, because there is—if their family members are able to put them in a car and drive them around, or, you know, walk them around the neighborhood—because it helps the home health—it helps the spouse. It helps the daughter or the son or whoever might be taking care of them as well.

Mr. Secretary, CBO looked at the amendment, and they determined that there is going to be a $1.5 billion increase in home health care benefits as a result. That is, there will be a whole raft of people who will be arguing that—you know, that they now have Alzheimer's or Parkinson's. And as a result, the home health care costs will go up in the country.

We contend it is just the opposite. We contend that it is the last thing most families want to do. My mother died from Alzheimer's. It took 5 years for my father to admit it, you know, because families aren't rushing to receive certification from a physician that their family member has it.

But once they do have it, the spouse, for the most part, is trapped with the other spouse, because they care for them so much in the home. And if they can walk them down the stairs, put them in the front seat, strap them in, and take them for a ride, in the sixth, seventh, eighth, ninth, tenth year of this disease, and they are still trying to keep them at home, I just don't think anyone is going to all of a sudden try to engage in fraud and argue that they have the disease when they don't.

So we wrote to CMS, you know, asking them to evaluate the CBO number, which we think is—Senator Dole and Senator Collins and I, we just don't think it is an accurate number, and we have asked for a response from CMS, which we haven't officially received yet.

So that is what I would like to work with you on, Mr. Secretary, because I think it is—it is something you can give to people at home. It doesn't really cost anything, and it just makes the whole home care system so much more efficient, and it will keep people out of nursing homes, which would have a dramatically escalating, you know, drain on the Federal budget.

Secretary THOMPSON. Thank you very much, Congressman. And I know you are very concerned about this and about the definition of the homebound, and I thank you for it. And I thank you for your urging for us to look at this.

I want to report back that because of your urging CMS did relax the ability for a family to take a person out of their home last year, and it was because of you we issued a clarification to permit individuals to leave their homes to attend, for example, a family event, and that was at your urging.

I might add that this clarification, of course, was in large response—was with regards to your inquiries. And I want to work with you on it, because I think that you make some very valid arguments. And I don't see where it is going to cost as much as CBO scored it.

And I know that you have sent a letter, and you are going to receive a response. It is being worked on, and you will be receiving a response, as I understand it, in the next 10 days, Congressman. And if you don't have it within 10 days, I will call you directly. But I am confident that we will, and I am confident that we can work something out here that will be agreeable to you and agreeable to the patients that really need it.

Mr. MARKEY. Can I just make this point to you, Mr. Secretary——

Secretary THOMPSON. Sure.

Mr. MARKEY. [continuing] and I know—and I appreciate the fact that there was some movement last summer saying that they could be taken out for a special occasion. But in my own personal experience, for example, with my father who was healthy enough in his eighties to take care of my mother in her eighties, is that if he could walk her down the stairs and put it—put her in the front seat of a car, strap her in, and what he did was he just basically duct-taped the door so that she couldn't open it from the inside, he could go drive her down to the beach, sit there, read the paper, sit next to her, you know, and 1½ hours later go home.

Now, that is not a special occasion, you know?

Secretary THOMPSON. No, it isn't.

Mr. MARKEY. But it meant the world to him, you know, and it kept him going. And I just don't think—you know, they don't—these old people they don't want to admit that they have these diseases. No one is—there is no fraud. No one is going to contend that they have it.

And I just think that it helps the system so much, but it helps these heroes at home, you know, because it is such a burden on the

family member, you know? So I would hope that you could look at it.

Secretary THOMPSON. Congressman, sometimes we become very bureaucratic, and I am not noted for that. And I can assure you that I will—this has just been elevated to the highest levels, meaning my office, and I will get a response back to you within 10 days. I thank you for it.

Mr. MARKEY. Thank you.

Chairman TAUZIN. Would the gentleman yield a second? I just want to advise the Secretary that I have never had a worse experience in my life than trying to get CBO to reconsider the extraordinary dollars they put on the language Mr. Markey was trying to work out to solve this simple little, as you put it, bureaucratic problem. I wish you good luck.

Secretary THOMPSON. Maybe we can administratively solve the problem.

Chairman TAUZIN. I think you can, and I would urge you to work with Mr. Markey to find a way to do it, so I don't have to deal with CBO on this again. I don't want to ever have that experience again. I thank you.

Secretary THOMPSON. I can assure you, Congressman, we will work with you——

Chairman TAUZIN. Thank you, Mr. Secretary.

Secretary THOMPSON. [continuing] and Congressman Markey.

Mr. MARKEY. Thank you very much for——

Chairman TAUZIN. Thank you, Mr. Markey.

The Chair recognizes Mr. Upton for 8 minutes.

Mr. UPTON. Thank you, Mr. Chairman. I would like to underscore Mr. Markey's comments. I tried to act as an intermediary last year to try and get this resolved, and I gave my full faith and commitment to do so and was frustrated to no end as well. So I will stay in touch with my friend from Massachusetts in that regard.

I do have a couple of questions. First of all, welcome back to the committee.

Secretary THOMPSON. Thank you, Congressman.

Mr. UPTON. You know, last year I thought we passed a pretty good prescription drug bill. And as I hold town meetings throughout my district, I don't think there has been a time the last couple of years that we haven't had prescription drugs as being one of the top issues that my constituents raise.

And I remember well last year leaving my son's little league game, and a young woman ran up to me and her mom had just had a stroke. And the family was not prepared for the $600 monthly charge that she would—they would now have to be paying to take care of her.

And she asked me whether the bill that we passed would, in fact, benefit their family, and the answer was yes. It was within a week or 2 of the House action that we had here.

But the Senate failed us. They didn't pass the bill. And here we are at it again this year, and I know that it is one of the top priorities for this committee to report out legislation and get to the floor, and hopefully we will see the Senate pick up the ball and begin to move it down the field.

And there have been a number of us, professors say probably on both sides of the aisle, that are somewhat alarmed to a degree with some talk, maybe a trial balloon about—with the prescription drug benefit actually forcing folks, if they do participate in this new program for Medicare prescription drugs, of linking the two and being forced to go into an HMO or a Medicare Plus Choice type arrangement.

I just wanted to hear from you whether that is—it is on the table for discussion, whether it is likely to be in an administration package, whether you are looking at it, or whether it is likely to be rejected. I saw today the Speaker of the House had some pretty strong comments against it. I think it was in The Post, but I think it was an article that he had talked to some reporters from The Chicago Tribune.

I don't have those comments in front of me now, but where are we in terms of the administration of forcing the two to be together versus the legislation that the President said that he would sign last year with regard to the House passed bill?

Secretary THOMPSON. Congressman, first, let me just tell you that we are still working on the Medicare proposal. Decisions have not been finally made. We are working extremely hard on it, and hopefully we will have those decisions made within the next several days, and hopefully within the next 2 weeks.

Second, I can guarantee you that there is not going to be any attempt whatsoever because—just it is not going to happen, to force seniors into HMOs in order to get prescription drug coverage.

Mr. UPTON. Great. I am glad to hear that answer. Thank you.

Mr. Secretary, last year we in the House moved I thought relatively quickly to pass a West Nile Virus bill, thanks to Chairman Tauzin and Mr. John. It was a bipartisan bill. Michigan was No. 2 in the country in terms of deaths. I think we have had close to 48—close to 50 deaths. This last year, we had 574 cases.

Obviously, it is not mosquito season now with lots of snow coming down in Michigan. But come spring, we will begin to think about this again. Where are we in the efforts of the Department to not only help States but actually find—whether it be a virus or a vaccine or some cure for this disease? I happen to know a number of people that, in fact, were infected with the West Nile. Thank goodness they were survivors.

But it alarms me as we look into another season, next year, particularly if we don't have the drought that we had this year, or this year being last year, 2002.

Secretary THOMPSON. Last year, NIH spent $18 million in fiscal year 2002 and is going to spend approximately $27 million this year. We have conducted Phase 1 clinical trials for two West Nile Virus vaccine candidates, and that is going to commence this year.

We got some early research done to investigate a DNA vaccine approach to protect against the West Nile Virus, and the basic research on the West Nile Virus is being expanded, as I indicated, from $17 million to $27 million to accelerate our understanding of the disease, so it is able to enhance our research and development efforts.

We feel pretty good about the preliminary studies on the two vaccines that we have, but we have to go through the human clinical

trials, and they will be started this year and go through three phases. Phase 1 will be starting within—hopefully within a couple of weeks to a month, and then we will go into Phase 2 if that Phase 1 is promising.

Mr. UPTON. Well, that is very good news. That is very good news.

Mr. Secretary, as chairman of the Subcommittee on Telecommunications and the Internet, as well as a member of the Health Subcommittee, I have had a focus on telemedicine. My district is pretty diverse. It is a good microcosm for the country in terms of a blend of urban and rural. You know, Kalamazoo is in my district.

I have got two large hospitals there, Borgess and Bronson, each with 600 physicians. But I have got some hospitals in some counties that are very rural, and they don't have, obviously, the equipment that a university hospital or a major institution might have. And as we have looked at telemedicine, we have seen that this really could be a breakthrough for providing great care for patients in urgent need.

And I have talked to my colleague Chairman—Mr. Bilirakis about having some hearings on this maybe this fall, looking toward telemedicine. Where is the Department's priority in terms of its budget on telemedicine? What type of projects are you looking at in the 2004 budget for promoting telemedicine and the advances that we know clearly would be there?

Secretary THOMPSON. We have gotten an increase of about $5.6 million in telemedicine production and promotion, and trying to expand it is something that you and I come from rural areas. I am from Wisconsin. You are from Michigan. But there is no question that telemedicine is something that we have used very effectively in our clinics and rural areas in Wisconsin. I know you do that in Michigan, and that is——

Mr. UPTON. You know, just one—right. You know, we are going to probably have the malpractice bill up on the floor in the coming weeks. One of the things about telemedicine, particularly when you have got a State—Michigan, we look at different institutions, different physicians. We have got University of Michigan Hospital. And often cases you have got expert advice that is crossing State lines.

Secretary THOMPSON. It really is.

Mr. UPTON. And so we get to the malpractice problem. Might the Department have any suggestions as we look at——

Secretary THOMPSON. We are working in a collaborative fashion with a lot of universities and a lot of States on this thing, and we are hoping to be able to push it further down the field. My only suggestion and advice to you, Congressman, is that I wish the University of Michigan would spend more time on this and less time on football. We would be much better off.

Mr. UPTON. Too bad. This is the big house, after all.

I yield back my time.

Chairman TAUZIN. The gentleman's time has expired, and the Chair will recognize the gentleman Mr. Brown, I believe, for 5 minutes.

Mr. BROWN. There seems to be a sort of Orwellian air in this city. The President at the State of the Union said, "We will not

pass along our problems to other Congresses, to other Presidents, and other generations." And then, a few paragraphs later, he proposed a budget that was $300 billion in deficit, with deficits as far as the eye can see.

He talked about bureaucrats and HMOs and got a great standing ovation and applause lines saying that doctors and patients should get—we should have those insurance company and HMOs get them out of the doctor-patient relationship. And then, a few paragraphs later, he proposed to push people that wanted prescription drugs, push them out of traditional Medicare into private plans.

And then, listening to Mr. Waxman, and you, Mr. Secretary, we see that the President is proposing capping funding for Medicaid, even though there are specific increases, but capping funding and then deny that it is block grants.

I want to explore that a little bit. Secretary Thompson, you had said that Federal spending for Medicaid will grow at 9 percent per year under the block grants. That sounds good until you realize in the last—in 2001, Medicaid expenditures rose 11 plus percent. In 2002, Medicaid expenditures rose 13 plus percent. We don't see likely anything better in 2003.

This increase obviously is significantly above the 9 percent, and it is driven mostly by the economic downturn. Medicaid actually has done better than the private sector, as Medicare has, in keeping costs down. But nonetheless, with more people out of work with this economic downturn, with no real stimulus package proposed in this Congress, no one that seems likely to pass, these problems can easily continue. This 9 percent growth will leave States in a pretty bad position if—in this block granting kind of Medicaid situation.

The Federal law today contributes a percentage for every single person the State enrolls. In other words, the Federal Government will help meet those expenditures. Under your proposal, if I understand, each State's allotment will increase by a fixed percentage each year, correct?

Secretary THOMPSON. Let me just correct something. We are under—under the law, we have to project out for 10 years what the Medicaid costs are. That is the 9 percent. But we have already readjusted the 9 percent for next year to 10 percent, and so we readjust the 10 percent or readjust the growth factors on an annual basis, Congressman.

So it is not locked in to a 9-percent. That is point No. 1.

The second point is it is not a block grant, because the mandatory population, there is no cap on it. The mandatory population is the same under the existing law as it will be in the new proposal that we are going to advance.

Mr. BROWN. So it is locked into a percentage every year, and it is locked into that same percentage for every State. Correct?

Secretary THOMPSON. Every State—every State is not locked in because it is a—it is a guaranteed benefit. You are going to be able to continue to get that benefit. And so that—it doesn't change for the mandatory populations, Congressman. That doesn't change. So if the mandatory population increases, the money increases, and so will it under the current law.

Mr. BROWN. But you give it a percentage, but it doesn't necessarily meet the needs of the State, so it really is a block grant.

It is a defined—it is not a defined benefit; it is a defined contribution by you, correct? By the feds?

Secretary THOMPSON. The block grant is like TANF was. It was at $16 billion a year for 5 years. The Medicaid proposal—the Medicaid law goes up at a plane right now at 9 percent, which is going to be adjusted next year.

Mr. BROWN. But it has clearly not been enough. That is what makes it a block grant, because it doesn't—it is a defined contribution by you, not a defined benefit for the State.

Secretary THOMPSON. But the Federal Government has to pay whatever the State matches, whatever the Federal matches for that State for how much population. Every——

Mr. BROWN. Except the funding is capped, Mr. Secretary.

Secretary THOMPSON. Yes. But every year—every year the States have got to compute out. Every year the States have to compute out what their caseload is, and they drag—they have a drawdown, an allotment. Every quarter they use up the money, and then they apply to the Federal Government. We send them a check for the prior quarter, and then they go and spend the money, and then they get another drawdown the next quarter for the cases they have had.

Mr. BROWN. Is the money capped? Let me ask you specifically—I guess I have only got 3 minutes in this. I am not sure why that calculation worked.

Secretary THOMPSON. I am trying to——

Mr. BROWN. I guess that is a little like the Medicaid calculations perhaps. Is the money capped? Are you capping the money?

Secretary THOMPSON. Not in the mandatory population, no.

Mr. BROWN. But in the optional that really matters in people's lives, you are capping the money, correct?

Secretary THOMPSON. No.

Chairman TAUZIN. The gentleman's time has expired.

Secretary THOMPSON. The optional population is the same as existing law. This is where the confusion is. States right now—States, under the existing law, can change the optional population. States can drop it, and that is what they are doing right now.

They are dropping over a million people, and what we are trying to do is give them flexibility, Congressman, so that they will be able to hold on to those individuals. They may require co-pays. They may require differentiation in medical coverage. But we are trying to figure out a way to keep them covered. That is why we are advancing the payment of $3.25 billion, so the States will have this, which is—actually equates to a 2-percent increase in the Federal match.

Then we are reducing what the States have to pay in in order to get that dollar, which is another 1 percent on the Federal match. So truly it is a great deal——

Mr. BROWN. But if there is a newer——

Chairman TAUZIN. The gentleman's time has expired.

Mr. BROWN. [continuing] capped by the Federal Government.

Chairman TAUZIN. The gentleman's time has expired. I am going to ask everybody to hold to these agreements we made on time. I extended it to allow the Secretary to answer, but I have got to hold to these agreements.

Mr. Whitfield is recognized for 8 minutes.

Mr. WHITFIELD. Mr. Chairman, thank you very much.

And, Mr. Secretary, thank you for joining us today on this important issue. We hear a lot of criticism today about the administration on these huge deficits that are anticipated over the next few years. And I remember those in my class in 1994 who came—that was one of the things that we really focused on was trying to get out of deficit spending.

And I know the administration, as I said, is really being criticized about that. But at the same time, the administration is being requested to expand certainly health care programs. And I recently just read this little statement which is in Health Affairs today, and it is particularly talking about Medicaid.

And we all know that Medicaid, in 1966, cost $400 million. And in 1991, it cost $87 billion. And today it costs $257 billion. And so we all recognize that something has to be done. We can't just keep expanding a program.

And one of the comments made in here today is that one of the real problems with politics today is the growing number of people in public life for whom there is nothing important enough to lose an election over. And then, a comment is also made which we are all very much aware of, that today, for example, millionaires on Medicare are getting public subsidies—public subsidized health care paid for in part by poor workers who cannot pay for health care for themselves and their families.

And so I, for one, wanted to commend the administration for at least being willing to look outside the box to try to explore some new way of trying to provide a benefit, but also be responsible on the cost, because we are always talking about we need to expand the coverage, we need to expand the coverage, we need to expand the coverage.

But in the end, those people who are—their employer does not provide health care for them, they do not qualify for Medicaid because they earn a little bit too much, their payroll taxes are going in and their income taxes are paying benefits for other people, many times who are wealthy people, and they can't buy health care for themselves.

So one thing that I would point out, in these State health partnership allotments that you all are talking about, it is optional, is that correct?

Secretary THOMPSON. That is correct.

Mr. WHITFIELD. So it is not mandatory, but we are simply saying here we are giving the States the opportunity to see how innovative they can be in coming up with ways to deliver health care.

Secretary THOMPSON. That is absolutely correct, Congressman, and it is a voluntary program on the States. The States can continue on with the old program if they so desire, or they can volunteer to go into the new program, which is based upon the very successful SCHIP program. It is based on the very successful TANF program. There is some modifications because the TANF program and the SCHIP programs were block grants.

These are not block grants, because they continue to increase, and it also allows for the mandatory populations to be covered the same way that they are under the current law. It doesn't change

that at all. It only allows for the one-third of the population, which is the optional population, that the States—the Governor and the legislature have added, plus two-thirds of the options, which are optional. But they make up two-thirds of the cost of the Medicaid budget.

And what we are doing is we are going to give the States the options to be able to change the program, because under the existing Medicaid program if you put an optional population with an optional service into the Medicaid program, you have got to have it uniform throughout the State.

And I don't know what State you are from. I should know. I apologize. But if you have got a State like mine, you have some rural areas, some urban areas. What costs the State a great deal of money is when you have to have uniform services from a rural area that has fewer providers to an urban area, it costs more money.

And what we are going to allow under the optional population, if the States want to do this, is to allow for those areas in the rural areas to have a different kind of coverage, but continue to cover them, so they are covered by the Medicaid program. It would be much more innovative, and you know that States will be very innovative in this, and that is why we set this program up, Congressman.

Mr. WHITFIELD. Well, thank you. And, of course, we know that Mr. Waxman has been a real leader in Medicaid, and no one questions his motives of being dedicated to the program, providing the best health care that can be provided for as many people as possible. And he made the comment earlier today that this is a radical departure, and I just want to emphasize once again that we need radical departures if we are going to make this program to ensure that it is effective for the long term.

So one other point that I would reiterate on what you are looking at here is that you are not changing the mandates at all.

Secretary THOMPSON. The mandatory population stays the same. And I know you are from Kentucky, and I know that Louisville is No. 2, and Kentucky is No. 3. So you are doing well, sir. I apologize. But——

Mr. WHITFIELD. Well, I wasn't going to tell you where I was——

Secretary THOMPSON. But it is not—the mandatory population, the mandatory guarantees that Congressman Waxman was talking about, stay the same.

Mr. WHITFIELD. Right.

Secretary THOMPSON. They are not changed at all, and that also does not describe a block grant. It is different than a block grant.

Mr. WHITFIELD. Right. Right. Now, there has also been a lot of discussion today about prescription drugs and how horrible it is going to be to force people to lose—to leave fee for service and go to an HMO. And, obviously, we want to provide prescription drug benefits for people who need it. And I am sure the motive behind going from a fee for service or requiring—to an HMO is simply a cost consideration.

But in the President's proposal on prescription drugs—and I know you have indicated that you are certainly going to be working with Congress closely in developing that plan, even though there

was one the last year, are you all considering a co-pay or a means test to be eligible for the prescription drug benefit under Medicare?

Secretary THOMPSON. The President feels that everybody is entitled to prescription drug coverage, and there is not going to be a means test.

Mr. WHITFIELD. Okay. Well, I for one think that we should look at a means test, because just as this comment was made, I read earlier millionaires on Medicare are getting publicly subsidized health care paid for in part by poor workers who cannot provide health care for their own families.

And I know that it is a volatile issue. I know what happened to Danny Rostenkowski and others when, in expanding benefits, they asked that seniors pay a part of that, and there was an uproar and it was repealed. But I think we can make a strong argument that Warren Buffet, Bill Gates, and other people, when they become eligible for Medicare, should not have subsidized prescription drug benefits.

And so I hope that at least the administration would be open, that we can discuss that, and maybe pursue that.

Secretary THOMPSON. Thank you very much, Congressman, and thank you for your support.

Mr. WHITFIELD. Thank you.

Chairman TAUZIN. The gentleman's time has expired. I was going to hint to you that they had more horses in his State than people, but I was not going to tell you where he is from.

The gentlelady from California Ms. Eshoo is recognized——

Ms. ESHOO. Thank you, Mr. Chairman.

Chairman TAUZIN. [continuing] for 5 minutes.

Ms. ESHOO. Thank you.

Mr. Secretary, first, I want to comment about Stanford Hospital, which you mentioned in one of your remarks—in your remarks to—I believe in response to another member. The funding was for the select contracting provider waiver, and I was very happy and proud to write letters supporting that waiver.

And I concur. It is a very good waiver, because it saves money. But it didn't hurt people, you see? There has to be—my point in my opening statement was that when you provide the right pot of money in order to accomplish the same goals of coverage, but doing it in a different way, I support that.

The model that I set up in California before I came here is the first and only free-standing Medicaid program that was really modeled on a private sector model, and it is still working today, saving money, but also expanded the services to people.

So I think in this capitated system it went from a fee for service to a capitated system, but it was fair in terms of the funding, and it is a good waiver. And I want—I just wanted to say that.

There is a bill that I was the Democratic lead on that came out of this committee. It represented an enormous amount of bipartisan work, and that was on the medical device——

Secretary THOMPSON. I thank you for it.

Ms. ESHOO. [continuing] fee program. Thank you, Mr. Secretary.

Now, in order to make sure that this moves on, that the policy is actually implemented, it needs the dollars. It is like trying to get

a car going without—you either put fuel in the tank and make it run, or it doesn't.

Now, in the President's budget that was submitted, there isn't any allocation for any funding in this new fiscal year. Now, the user program in 2005 will cease to be.

Now, I think that, you know, some can say, "Well, it can be taken care of down the road," except the price tag is going to be larger. So I don't know what your recommendation or what you will—I mean, I think that you recognize how important this is. It represents a technology that is life-saving, technologies that are life-saving. It was bipartisan. The administration supported it, and now it is like close your eyes, what do you see? There is not a dime, and this needs to be taken care of.

I hope that you will come to the Congress and advocate with the appropriators for this. So, you are shaking your head, which looks very good to me. All right?

Secretary THOMPSON. Can I respond?

Ms. ESHOO. Yes.

Secretary THOMPSON. I want to stress three things. First off, the waiver.

Ms. ESHOO. I still have some questions, so—go ahead.

Secretary THOMPSON. Can I respond?

Ms. ESHOO. Absolutely.

Secretary THOMPSON. If you want to ask the questions, and then I will respond to all of them.

Ms. ESHOO. Great. Okay. Well, on that, the user fee. I also think that there needs to be some clarity in this hearing, because we are talking about block grant proposals and combining a number of different pots of money. Medicaid spending on coverage, the SCHIP spending, spending on administration activities, and spending on disproportionate hospital share of moneys. And that is correct; you are shaking your head.

What happens to the DSH money when it gets folded into the pot? Do States have to continue to operate their DSH programs like they do today? Will there be standards for this? I know that there are some abuses of DSH, but I want to tell you something, I have seen it firsthand in my own communities and in California.

And I am not suggesting that we defend things that aren't defensible, but I am going to rise to the defense of those dollars that can be defended because that is what—that is the tool that allows my hospitals to take care of people that need to be taken care of. So if you could comment on that as well, and I will stop here.

Secretary THOMPSON. Thank you very much. First, on the waiver, it is $1.8 billion; $250 million went to Los Angeles County to maintain their hospitals. The balance of that money went throughout the rest of the hospitals, including your districts, to share among the hospitals. It was a very good waiver. I thank you for your support. We worked very hard in the Department to make that happen, and I think everybody appreciated that on a bipartisan basis.

Second, in regards to——

Ms. ESHOO. The medical device user fee.

Secretary THOMPSON. [continuing] medical devices——

Ms. ESHOO. And no money for it.

Secretary THOMPSON. Thank you. We worked very—that was actually a proposal from the Department of Health and Human Services, and we appreciated the bipartisan support. We are required to come in with $60 million, and I requested $15 million over 4 years. We have got to come up with——

Ms. ESHOO. Forty-five million dollars, I think, total.

Secretary THOMPSON. No, $60 million. We have to come up with the—the users are going to come in with $45 million. And so we have a responsibility for coming up with $60 million over 4 years. We requested in the Department $15 million for this budget, but OMB said we should wait until Congress acts for fiscal year 2003 to see what money the Congress puts in in this particular year in this project.

Ms. ESHOO. Well, right now, as far as——

Chairman TAUZIN. The gentlelady's time has expired.

Ms. ESHOO. Can I just respond to——

Chairman TAUZIN. The Chair has——

Ms. ESHOO. [continuing] the Secretary?

Chairman TAUZIN. [continuing] to stick closely to these limits, if we are going to get everybody in before the Secretary has to leave.

So let me—I have to move on, Mr. Secretary. Otherwise, some members are going to miss the opportunity to ask questions.

The Chair recognizes the gentleman from Florida, Mr. Stearns, for 8 minutes.

Mr. STEARNS. And thank you, Mr. Chairman, and I appreciate your being punctual on this. And I think all of us should work with you because under the new rules a person can have ample time through 8 minutes.

I have four questions I would like to get in. The first one is in my opening statement I talked about the Family Directive Services, in which three States are using the waivers to go ahead. And I provide—in my opinion, it is basically letting people on Medicaid show personal responsibility and have choice and get them involved with their health care. And I am just curious if you thought all the States should do this, and you might just give a little comment on it, just as a general statement.

Secretary THOMPSON. There are three States that are doing it right now—New Jersey, Arkansas, and Florida. Every State that has said that it is working well by the people, it is cash and counseling, that the people get the money, they are able to make the decisions for themselves, and it has worked out. They have saved money, and everybody is happy about it. I think it is a concept that should spread throughout America, and I know that a lot of people are looking at it.

Mr. STEARNS. And I think your point is well taken. With the mounting costs in Medicaid, unless we get the participants to accept some personal responsibility in choice, these costs go on and on and on.

Let me take you to something that is a little bit more controversial, and that is I have supported the doubling of the funding for NIH. And I think many members on this committee have.

In 1996, the Institute of Medicine report suggested that the funding at NIH—that funding decisions are a little politicized. And they base this based upon the number of deaths. And if you look at the

number of people who die from heart disease, and die from cancer, and from strokes, from chronic lung diseases, pneumonia, diabetes, these are all in multiple proportions that the people die from AIDS in America.

Yet the money that goes to AIDS is in multiple increases in what we give to diabetes, pneumonia. And, in fact, the money is almost twice as much for AIDS than for heart disease, but heart disease has—almost 20 times more people die of heart disease. So I guess the question is, Mr. Secretary, can't we do the research spending based upon the need rather than it appears to be the politics?

And I say this very deferentially, because we are always talking about more funding for AIDS. But when you look at the statistics of heart disease and cancer and stroke and chronic lung disease and pneumonia and diabetes, there are so many more people dying from these diseases than AIDS, yet the AIDS is getting so much more funding.

So I will give you a crack at that question.

Secretary THOMPSON. Well, it is not political, Congressman. I can assure you of that. They have peer reviews set up in every one of the institutes, and they have peer reviews looking at all of the research grants that come in. Eighty percent of the money that—75 to 80 percent of the money that NIH gets goes out in research grants, and this year with this budget it will be the maximum amount of grants ever given out by NIH.

There is a lot of cooperation and spillover from one research project to another. So dealing with anti-retroviral drugs and research on that, and a vaccine for AIDS, helps out in other diseases. And so it is the decision made by the scientists and the experts. I have nothing to do with it, but I will certainly share your views with Elias Sirhoney, the Director. But I am fairly confident that knowing the people out there there is no political machinations going into how the grants are given out whatsoever.

Mr. STEARNS. Okay. I am just trying to maximize our research efficiency.

Secretary THOMPSON. Thank you.

Mr. STEARNS. Another question is on September 21, 2001, our committee had a hearing on the average wholesale price, AWP.

Secretary THOMPSON. Right.

Mr. STEARNS. For drug reimbursement and payment of oncologists under Medicare. Then, the American Society of Clinical Oncology, the Levin Group, presented a report in September of 2002 on this. What are the plans? We keep hearing about this. What are the plans for correcting this gross misalignment that is dealing with the average wholesale price? Just briefly. I mean, it is a very complex——

Secretary THOMPSON. We have it in the budget. We are trying to fix any overpayment for outpatient drugs. The proposal is a slight change from the fiscal year 2003 budget proposal, which was not passed. We declared our intention to pursue a regulatory approach if Congress did not address the problem legislatively.

And we estimated that the regulatory approach is going to generate savings of about $5.2 billion over 5 years. So we are proceeding along the lines of——

Mr. STEARNS. Okay.

Secretary THOMPSON. [continuing] the administrative process.

Mr. STEARNS. Last question is, I know you have talked to Secretary Princippe. He has priority 8 veterans that can't get help under Medicare, and I just wondered if you and Secretary Princippe have touched on this idea of veterans who will be eligible to get into this Medicare Plus Choice. You might just briefly—my time has expired, but——

Secretary THOMPSON. Congressman, we are working on that, the Veterans Department and my Department, CMS, and the Veterans Department. I have personally met with Secretary Tonio Princippe, and we have knocked down a few of the barriers.

We are hoping to be able to solve the problem and set up what we call a managed care HMO between Medicare and the Veterans Department. But it is still in the embryonic stages.

Chairman TAUZIN. The gentleman's time has expired.

The gentlelady, Ms. McCarthy, is recognized for 8 minutes.

Ms. MCCARTHY. Thank you, Mr. Chairman.

Mr. Secretary, I want to commend you and your decision with the President to put in this budget and in your plan prevention of disease by including a request for $100 million to promote healthier lifestyles and targeting prevention of those diseases that you and I both know can be prevented—obesity, diabetes, asthma, clearly, and others.

I really appreciated your remark last year in The L.A. Times where you called on private insurance companies and businesses to do more to promote exercise in the workplace and encourage people to stay healthy. And as a result of that, my colleague from my neighboring State of Kansas, Jim Ryan, and I and others put in a measure sent to the Congress to promote healthier lifestyles and encourage insurance companies to provide discounted premiums for those who exercise regularly and also provide screenings of certain diseases that we know if treated early will, indeed, save money.

And you know the facts probably better than I, but if more—if the more than 88 million inactive adults in the United States began regular exercise, national medical costs would decrease by more than $76 billion. This is from research we found in our efforts to, you know, try to follow along with your lead on——

Secretary THOMPSON. Thank you.

Ms. MCCARTHY. [continuing] keeping people healthy will save Federal dollars. And knowing the crunch that we are in fiscally now, I wonder if you would—if I could leave some information with your staff about——

Secretary THOMPSON. Absolutely.

Ms. MCCARTHY. [continuing] this. We have reintroduced it today. It seems to make good sense, and I appreciate your taking the lead on this. And I loved the article. You said, "I am going to call on those insurance companies and tell them to rethink the way they do things, because the cost savings will be a benefit to them and to the taxpayers as well."

So that is—I kind of wanted to bring that to your attention and share that with you, because I do appreciate what you are doing.

Secretary THOMPSON. Thank you so very much. $155 billion a year in tobacco-related illnesses, 400,000 people die. $117 billion a year on obesity, and people are overweight, and 300,000 people die.

$100 billion on diabetes; 17 million Americans are diabetic, 16 million are pre-diabetic. And if we don't do anything, in 5 years those 16 million will be diabetic, and there will be another $100 billion.

And NIH has just done an exhaustive study. If you walk 30 minutes a day, 5 days a week, and you lose 10 to 15 pounds, the incidence of diabetes goes down by 60 percent. That is a savings of $60 billion right there. I am passionate about this. I put the whole Department on a diet, including myself, and we are losing weight. We are setting an example.

I have got everybody exercising. I am handing out these little walk-o-meters. If you want one, I will send you one. And it—you have got to do 10,000 steps a day, which equates to 30 minutes of good exercise, 3 miles a day. Everybody should do it. You don't go up in the elevator. You walk up the steps. You are healthier. We have got to do it.

Thank you so very much, and thank you for asking the question.

Ms. MCCARTHY. Thank you, Mr. Secretary. I love it.

Mr. Chairman, perhaps if the bill is reassigned to this committee again this year, we could invite the Secretary back and have the—fire up the whole committee on this.

Chairman TAUZIN. Perhaps we can institute such a similar reduction and exercise program at the committee. You look marvelous, Mr. Secretary.

Ms. MCCARTHY. Yes, you do, sir.

Thank you, Mr. Chairman. I would like to yield back, so that others might have some time.

Chairman TAUZIN. I thank the gentlelady for yielding back, and the Chair recognizes Dr. Norwood for 8 minutes.

Mr. NORWOOD. Thank you, Mr. Chairman.

Governor, welcome. Glad to see you.

Secretary THOMPSON. It is always a pleasure, my friend.

Mr. NORWOOD. And I am from Georgia.

Secretary THOMPSON. I know where you are from.

Mr. NORWOOD. I just want to make sure.

Secretary THOMPSON. Everybody knows where you are from, Charlie.

Mr. NORWOOD. Let me—I know we are here on the budget, and I have a lot of softball questions I could ask you on the budget, but I am not going to have time. So let us start trying to get at two things.

No. 1, the Medicare part. I am going to make some statements about it in hopes that you will correct me if you think I am wrong in my attitude about what I think is going on in Medicare.

It seems to me that there isn't a President Bush bill. There are some guidelines out there that have been aired that we are all thinking about, and they are all possibilities of a Medicare reform. Nothing is set in stone at this point.

I have heard comments, "Well, the President is going to do this, and the President is going to do that." I am not sure we are at that yet. But I do think that it is totally irresponsible for us not to consider why the President is asking for reforms.

As I understand it, if we don't do anything to Medicare, by 2030 it is going to take up 30 percent of the budget, all of our spending. And when we add a prescription drug benefit, which I believe per-

haps we will, we are talking about 35 percent of the budget. Therefore, it is totally irresponsible for us to not look at some options to change Medicare, so that it won't cost that much in the future.

My understanding is that we should give options to seniors other than just fee for service. And nobody has to choose any one of those options. Patients will be able to take their choice.

One of them, of course, is the fee for service that we presently have today, and my understanding—another one could very well be Medicare Plus Choice plans, which is basically managed care. A third could be insurance PPOs, and hopefully non-insurance PPOs.

The first one, fee for service, is administered by CMS. They control the administrative part of it as well as what they will pay. The other two are handled by insurance companies that they will do the administering of the plan. However, what we will pay will be determined again by CMS. Am I right so far?

Secretary THOMPSON. You are always right, to my credit.

Mr. NORWOOD. Not always. My concern, and I think the reason you hear some concerns from different people, is that basically patients, understandably, want all of the health care they possibly can use at no cost, and are accustomed to that in fee for service. And at the same time, CMS is sitting there trying to figure out, how do we not bankrupt this program by 2030?

When you get into the insurance programs, patients, again, want all of the health care they possibly could use at no cost. And then you have insurance companies being concerned about, do we make a profit here when we get to the bottom line?

There is a difference in those two concerns, but it is—in CMS we do have standards there, and we did that in 1997. We put some Medicare standards in there to protect patients, so there would be some things in which CMS and anybody else involved in Medicare couldn't cross that line.

And I think that it would probably give many people more comfort using the options, which I think we have to do, too, Congressman Allen, if we set some standards, legislatively would be fine, but my question is, can't your Department set some basic standards for which they can't cross that line, too, which means that it makes it much harder for the insurance industry to ration care and deny care.

Secretary THOMPSON. We can, if you give us the authority to do so. We would be more than happy to do that, Congressman.

Mr. NORWOOD. You can't, by rule and regulation, now do some of that?

Secretary THOMPSON. We can do some of it, but not as far as you want to go, Congressman.

Mr. NORWOOD. Well, that is probably right. You probably don't want to go as far as I want to go, and I would have to do that the hard way. But it would give, I believe, people a lot more confidence, Members of Congress included, if they knew that the industry—the insurance industry simply didn't get to make all of the decisions about what basically happens to a patient.

So I hope you will consider that as we draft and pass a Medicare reform bill, that some of the responsibility I hope will be with your agency as well in order to protect these people as we turn the administration of their care over to whomever insurance company.

Secretary THOMPSON. As you know, I worked with you and your office very closely on the privacy rules and the patient bill of rights. And I can pledge to you that we will continue to do so on the Medicare proposal. And I appreciate your ideas, and I will take them back and discuss them with my peers at the White House.

Mr. NORWOOD. If we leave Medicare as is, and it is going to take a third of the budget by 2030, which I feel sure we will pass a prescription drug bill which is going to add cost at a time when cost is a real problem, what is going to happen to long-term care as we age in this Nation? And is long-term care going to continue to be a cost to Medicaid? And why is it in Medicaid to start with, since it generally is about patients who are normally on Medicare?

Can you envision anywhere out there that long-term care would be picked up? Somebody is going to have to pay for what is going to happen in long-term care.

Secretary THOMPSON. That is correct.

Mr. NORWOOD. It is either going to be the State government and the Federal Government, or the Federal Government.

Secretary THOMPSON. I think, Congressman Norwood, it certainly should be considered as part of the revitalized and strengthened new Medicare. I think it makes much more sense in that regard, and I appreciate your comments on it.

Long-term care has really never been—I know this committee has held hearings on it, but long-term care has never ever really been addressed like it should be. There should be a tax credit for people that are applying for long-term care insurance. We should be doing that.

Right now, we should be getting out more information on long-term care insurance. We should be looking at ways to revitalize and strengthen Medicare, and that is what we are doing. And I think we should do the same thing on Medicaid, and I think we can make a lot of progress.

I know there is a lot of people on this side of the committee room that do not believe that we should do anything with Medicaid, and I am here to tell you it is going—it is going to bankrupt the States unless we do something. And the proposal that I have advanced makes a lot of sense.

And if you just got away from the idea of it being a block grant, which it is not, but I know that is the easy way to demagogue it—but if you wanted to work with it, we can make a great deal of progress to come up with a very beneficial Medicare and Medicaid proposal. And I think and hope and pray that is what we are going to be able to do this year.

Mr. NORWOOD. Last quick question, if I may. NIH—though you are only increasing that 2 percent, NIH budget is going to increase considerably more than 2 percent when you count the moneys going to NIH for Homeland Security to do research and development and produce vaccines. Am I correct?

Secretary THOMPSON. You are absolutely correct. The research budget at the NIH is going to go up this year—the research portion—7.5 percent. And that is even before the money comes in from Homeland Security. This is money that we spent last year to build laboratory security, laboratory buildings.

We are taking that money that went into capital construction last year, and this year, and fiscal year 2004 budget. We will turn it into research. So the research budget, even though the additional new money is $539 million, the actual amount of money that is going into research, without the Homeland Security, which is another tranche of money, is going to be $1.9 billion.

Chairman TAUZIN. The gentleman's time has expired.

Mr. NORWOOD. Thank you, Mr. Chairman.

Chairman TAUZIN. The Chair recognizes the gentlelady Ms. Capps for 5 minutes.

Ms. CAPPS. Thank you, Mr. Chairman.

And, Mr. Secretary, you know what I am going to talk to you about, and would ask you to please comment on a conversation we began in an airport last weekend on the funding levels for nurse education that are woefully short in this budget.

Can you give me some assurances that we can work together to increase that amount, which is so critical for all of the reasons—long-term health care, but also our homeland security? But also, would you comment—I am not just a nurse, I am also a school nurse. SCHIP has been a way to increase coverage for populations, and our numbers of uninsured have just been skyrocketing.

Would you comment on the way that this will be included with Medicaid and so-called flexibility with the States? And also, I was there when it came out, and I saw how awkward it was to get families enrolled. Let us not use the historical numbers. Can we focus on a way that it could meet the needs now? And also, is there a way, with this flexibility, that we can guarantee this money will go to children?

Thank you.

Secretary THOMPSON. You have got a lot of questions.

Ms. CAPPS. I know.

Secretary THOMPSON. Let me quickly—first, let me thank you for your leadership on the nurses bill.

Ms. CAPPS. Thank you for your help, and this committee was terrific.

Secretary THOMPSON. This committee, Chairman Tauzin, and you, were outstanding. Everybody was, and I thank you for it. The only reduction actually is an administrative one. It is not—it is administrative. We had to take an administrative reduction, and that is the $300,000. The actual money going to the nurses program is the same.

I would like to have said that it was going to be more, and I will work with you on it. That was your question. I would be more than happy.

We have got acute problems, and we have to do it. We also have to do something about encouraging more nurses to get into the profession of teaching. You and I discussed this.

Ms. CAPPS. Yes.

Secretary THOMPSON. This is a shortage. This is the bottleneck right now.

Ms. CAPPS. Yes.

Secretary THOMPSON. Because the applications are going up, but we don't have the professors and the people that are doing the

teaching necessary to get the increased number of students to go through the nursing profession.

So I thank you. I am looking at some ideas on that. I am going to come and talk to you about it. I thank you.

The second thing—in regards to the Medicaid proposal right now, the States get checks. The States get a DSH check. The States get an SCHIP check. And the States get a Medicaid check, and they get an administrative check. What we are going to do is we are going to, if the States want to do it on a voluntary basis, combine that into two checks, one for acute care and one for long-term care, for those States that want to do it.

The voluntary program is going to allow for the States to use the SCHIP money. As you know, not all of the States are using the SCHIP money.

Ms. CAPPS. I know. But they——

Secretary THOMPSON. And California is one of them. They send it back. Under the new provision, they will be able to use that SCHIP money. There will be no turnback. They will be able to use that money for children.

Ms. CAPPS. Okay.

Secretary THOMPSON. And be able to do that. And if you could only just give me an opportunity to explain this very quickly. What we are going to do—right now, the States have got to put in an allotment. They get paid down on a quarterly basis. What they are going to be able to do is they are going to have two accounts. They are going to have a long-term care and acute care.

This money is going to come in. They are going to have to maintain the mandatory populations under the mandatory guarantees that the population has right now.

The optional population that the States now have added on, with the Governor and the State legislature, those are the ones that are being dropped. But we are hopeful with the new amount of money, the additional $3.25 billion, will come in, and it will come in to the States. They will be able to maintain their commitment to that population or be able to change it.

So in Northern California, they may be able to give different services, different co-pays, for people in the southern part of California for the optional population or optional services. We are hoping that will allow them to be able to develop a better program. We are hoping that States will come in with a guaranteed minimum of insurance for the program and be able to set up an insurance program for their citizens and the optional populations.

And then, the third thing is if they go into the voluntary program, they will get the additional money—$12.7 billion over 7 years. But to get this money, they are also going to have to pay less, because under the existing law, in order for the States—in order to get the money, the Federal match, they have to do every year three things. They have to take into consideration the increased population, the utilization, and the indexing increase of the medical costs.

And we are saying under this proposal, if they do it, we will waive the increased population. We will waive the utilization. The only thing the States will have to pay will be the indexing increase of medical costs, which is a reduction of the amount of money that

California will have to pay if they take the deal, or any other State will have to pay, which actually adds up another 1 percent in the Federal match, which makes it 3 percent.

So the States are going to get the flexibility. They are going to get the opportunity to extend the benefits if they so desire. And they will be able to get more money and less payment in to get it.

Ms. CAPPS. Could I ask you to—it sounds like the SCHIP might be part of that non-mandatory population.

Secretary THOMPSON. That is what it is right now.

Ms. CAPPS. Right. And what I am curious—in followup with your staff, could we find out how much of the $3.25 billion our State of California would be getting under this new proposal?

Secretary THOMPSON. Sure, I can get that.

Ms. CAPPS. And I would like to get that——

Secretary THOMPSON. I don't have it off the top of my head, but——

Ms. CAPPS. You and I are going to work on the nurse money, because I—that conversation is ongoing.

Chairman TAUZIN. The gentlelady's time has expired.

Ms. CAPPS. I know.

Chairman TAUZIN. The issue has not.

Ms. CAPPS. Thank you.

Chairman TAUZIN. And we will keep working on it.

Secretary THOMPSON. If you would just get over the thought that this is a block grant.

Ms. CAPPS. I didn't use the word.

Secretary THOMPSON. And look at the tremendous opportunities that a State like California, or any State would have. I am confident that I could convince you that this is the right thing to do. And I am confident that States, on a bipartisan basis, are going to support it.

Ms. CAPPS. But this——

Chairman TAUZIN. The gentlelady's time has expired.

The Chair recognizes the gentlelady Ms. Wilson for 8 minutes.

Ms. WILSON. Thank you, Mr. Chairman. My colleague, Mr. Shimkus from Illinois, was not able to stay, but he asked me to read this statement into the record.

Right now, the State of Illinois receives the lowest Federal match allowable by law. While serving 4.5 percent of the national Medicaid population, Illinois receives only 3.6 percent of Medicaid funds.

Mr. Secretary, I thank you for being here today, and I wanted to talk about two things and ask you a question. In New Mexico, if my neighbors, the Batemans or the Garcias, who are both elderly, if they go to the doctor, the Federal Government reimburses that doctor for a doctor's visit of $57.22. If they lived in New York, your Department would pay that doctor $75.50, about a third more.

And it is not just the elderly. My daughter—our family is covered by managed care, but we had to go for some out-of-network care recently. They tie what gets paid to the Medicare reimbursement rates that are set by the Federal Government. If you were talking to a doctor in Albuquerque or Bernalillo, New Mexico, what would you say to him to convince him to stay in New Mexico and practice

medicine rather than go to Texas or Colorado or New York or Florida where he could get a 30 percent raise?

Secretary THOMPSON. I would tell him that New Mexico is a beautiful State to live. It has got a great quality of life, and I would strongly urge them to come and live there.

What you are asking me to do is to change something that I cannot change. There is a statutory way that we determine the reimbursement formulas on Medicare. Seventy-one percent of the reimbursement formula, which was set up a long time before I came here, was set up because of the wage costs. And it just happens that New Mexico wage costs are lower than they are in New York, and that makes up 71 percent of the reimbursement formula. I can't change that. You can change that; I can't.

Ms. WILSON. But that is a wonderful segue, Mr. Secretary. Today, we have introduced and reintroduced, both in the House and the Senate, the Medicare Equity Act that tries to address this problem, and recognize that we have a national market for health care providers, not a local market, and that these provisions and law are creating a shortage of health care in States like New Mexico. And I very much appreciate your help and support for making the system more fair, because it is killing us.

Secretary THOMPSON. Congresswoman, I agree with you. You know, when I was Governor of the State of Wisconsin, it was my—Wisconsin got less reimbursement than the State of New Mexico. And so I was opposed to the system as it was then. But I can't change the law. I can tell you what the problem is. I can encourage changes. We need to modernize it. That is why Medicare really needs to be handled this year.

We need to really do a real housecleaning on Medicare and strengthen it, take care of some of these inequitable situations, and try and improve it. And I thank you so very much for the question.

Ms. WILSON. I did want to ask you and commend you and the President for your leadership on the problem of HIV and AIDS. Mr. Brown and I on this committee are focused on the issue of tuberculosis. And as you well know, 15 percent of the AIDS deaths, and half of the AIDS deaths in Africa, are—actually, the immediate cause of death is tuberculosis.

Secretary THOMPSON. That is true.

Ms. WILSON. And it affects—it is not only a national—an international crisis and a crisis in Africa, there is the growing problem of multi-drug resistant tuberculosis that has huge impact here in the United States.

And I know that when we talk about the AIDS program and this major initiative that you are undertaking and leading, we lump together sexually transmitted diseases, HIV, AIDS, and tuberculosis, at the CDC. And I wanted to ask you if you could be a little more specific as to what is included in this effort to eradicate tuberculosis, because we have the treatment available now to go after it in a worldwide way to eradicate the problem.

Secretary THOMPSON. Well, most of the dollars are going to go to the Department of State. The portion that we have is really for mother-to-child transmission to mother to child. And it is a wonderful program, and we have set up a program. It was a result of my visit to Africa. I came back with Tony Falchua. We visited several

countries last April, and we came back and we said, "We have to do something for the mothers and children."

And we came up with this program for mother to child, and that is——

Ms. WILSON. I am sorry, sir. Is this for tuberculosis or for AIDS?

Secretary THOMPSON. It is for AIDS, but it also is going to have a tremendous impact on tuberculosis. We do not have the real program on tuberculosis. That is really in USAID. The program we have is for mother-to-child transmission. It is——

Ms. WILSON. Are you familiar with—or should we just ask the State Department as to of this huge new effort we are undertaking, are we going to within that effort be able to focus the resources and eradicate tuberculosis?

Secretary THOMPSON. Absolutely, because it has to be. As you have indicated, the evidence is quite overwhelming. The number of deaths come from tuberculosis, the majority of the deaths do. And we are hoping that through Congress, and with the President's valiant leadership on this thing, that we are going to be able to work with States through the Department of Health and Human Services and be able to develop more programs on tuberculosis, malaria, and also on fighting the HIV/AIDS.

And the President is absolutely committed. I appreciate your question. I thank you for your passion on the subject. It is a huge fight, and I just think the President should be congratulated each and every day for his leadership on this effort.

Ms. WILSON. Thank you. Mr. Chairman, I yield the balance of my time, so that others can have an opportunity to ask some questions.

Chairman TAUZIN. I thank the gentlelady, and the Chair recognizes the gentleman Mr. Strickland for 5 minutes.

Mr. STRICKLAND. I have only one question, and I think it probably won't take the full time. Thank you, Mr. Chairman.

Mr. Secretary, your budget would commit about $200 billion in new funding for a State voucher program for substance abuse treatment services. According to your budget, "This new State voucher program will increase substance abuse treatment capacity, consumer choice, and access to a comprehensive continuum of treatment options, including faith in community-based organizations."

In your submitted testimony, you state, "For some individuals, recovery is best assured when it is achieved in a program that recognizes the power of spiritual resources in transforming lives. Under this new program, individuals with a drug or alcohol problem who lack the private resources for treatment will be given a voucher that they can redeem for drug treatment services. The program will give them the ability to choose from among a range of treatment options, including faith-based and community-based treatment facilities."

Mr. Secretary, I agree. I, at one time, served as a United Methodist Minister, and I certainly agree that faith-based programs can be an important source for those struggling with substance abuse problems. However, I do have a concern. How will the program you envision ensure that the providers of services to those who use these vouchers are qualified? And will there be standards for licensure or standards for training?

And one further aspect of the question. As you know, many people who suffer from substance abuse also have co-occurring mental illnesses. How will this voucher program ensure that those who have these dual diagnoses are able to receive appropriate care?

Secretary THOMPSON. Congressman, first, thank you for your leadership in this effort. I know of your background of being a psychologist and a minister, your tremendous compassion for this particular subject. It is—the voucher program is going to be set up through the Governor's office and the State legislators. And the Governor is going to have to set up the program, and they are going to have to be accountable to the Federal Government for their performance.

They are going to have to set up the performance standards and how the program is going to work in the individual State. We are not going to mandate it from the Federal Government. The President feels very strongly that we need to get this money out to the States as quickly as possible, unencumbered, as much as possible, with the overall responsibility for the Department of Health and Human Services to monitor what the States do and how they set up their performance.

Mr. STRICKLAND. Thank you.

Mr. Chairman, before I yield back my time, let me say that I disagree with the Secretary about a lot of things, but the Secretary is somebody that I personally admire and respect, and I just—I wanted to say that. Thank you for your time today.

Secretary THOMPSON. Thank you very much, Congressman. I appreciate that very much.

Chairman TAUZIN. Let me, for the sake of the members and for the Secretary ask the Secretary, how much time do you have remaining to share with us?

Secretary THOMPSON. If I could go to the bathroom, I could probably stay all afternoon, Congressman, but——

Chairman TAUZIN. Would you like a break at this point? We have about 4 or 5 other members who are on the list to ask questions at this point.

Secretary THOMPSON. If I could be out——

Chairman TAUZIN. How about we take a 10-minute break? We will come back in 10 minutes. Let us do that. Is that okay?

Secretary THOMPSON. No, let us go ahead.

Chairman TAUZIN. You want to go ahead?

Secretary THOMPSON. Yes, sir.

Chairman TAUZIN. You are healthier than I thought. The Chair recognizes Mr. Buyer for 8 minutes.

Mr. BUYER. Thank you. Noted that there has been a 165 percent increase since 1990 in the Medicaid program.

Secretary THOMPSON. That is right. It is the fastest-growing program that we have.

Mr. BUYER. I also note that much of this has been caused by States which have expanded program eligibility, added new benefits in the areas, whether it is for weight loss, substance abuse. The list goes on and on. some have even accused some States of operating the gold-plated Medicaid-type program.

When you talk about reforming Medicaid, what role, if any, should the Federal Government have here? I am kind of caught be-

tween this policy of trying to give greater authority or flexibility, empowerment to States, but you have got some States that absolutely have gone way overboard where other States have tried to act responsibly. And you just can't say, "Well, Federal Government, give me more money, give me more money."

And it is almost caught where, what, is the Federal Government going to have to come in and say, "No, we are only going to send money for these types of elective procedures"? I am just curious if you can expand on what type of reform you are going to recommend.

Secretary THOMPSON. Congressman, the Medicaid budget is growing faster than Medicare and faster than any other program. And we are trying to address the Medicaid problem by looking at how successful we were with SCHIP and TANF. And we gave the States block grants for those programs. We are not block granting the Medicaid program.

But what we are doing is we are going to allow the States and the optional population, which is one-third of the population but two-thirds of the cost, because it also allows for the States to come up with programs for two-thirds of the options. It is two-thirds of the cost of Medicaid.

To allow States to innovate, such as the State of New Mexico, which came in with a HIFA waiver—half of the population of the State under 2 percent of poverty was not insured. Under the waiver, the State will contract with managed care organizations for a benefit package.

Utah, a primary care network, it was able to take—Utah was able to take a waiver that I gave them and take a population which had higher benefits than what the Governor and the State employees and the State legislature had in Utah.

Mike Leavitt, the Governor there, came up with an innovative idea and said that if I could reduce the Medicaid population, which is optional, to have the same benefits as the State health contract, I could extend the benefits to at least 25,000 more people that live in Utah and save money. And I thought that was a good idea, and so we did it, and he did it. And that is another one of the ideas we have.

A third way, in long-term care, if a State would voluntarily go into the program on long-term care. The way it is right now, the usual way to do it is to put individuals into a nursing home, an institution, because the money follows the decision by the State and goes to the institution. We think a better approach would be that the money would go to the person, would follow the person, and allow that person to be able to have their independence and make a choice to live in their own home. It would be easier.

Three States—the States of Florida, Arkansas, and New Jersey—came up with an idea on cash and counseling for the disabled community. And we gave them the opportunity to try something new, and we gave them—those States gave those individuals the cash to make the decisions to buy their own medical care.

The people loved it. The States loved it. And they save money. These are just a few ideas off the top of my head that a new Medicaid proposal would be better for the individual. You could actually

expand the coverage, and you would have better coverage and be able to allow for some savings of dollars for the States.

The final thing is, in Medicaid, in order to get Medicaid it has to be uniform. You will go into a particular program, and every State is different. You have urban areas, and you have rural areas. And you are not able to always give uniform treatment in coverage from a rural area versus an urban area. It is more expensive, if you have to have the same type of coverage in a city as you do in a rural area, in some instances. In some instances, just the opposite.

But what we are trying to do is allow the States the flexibility to look at their State, to manage their Medicaid budgets, and be able to develop better innovative programs to meet their optional population. At the same time, maintaining the guarantees for the mandatory populations that Congress, you, and every other Member of Congress has said we should do.

Mr. BUYER. I have a specific question in the area of fraud.

Secretary THOMPSON. Did I answer your question?

Mr. BUYER. Yes, thank you. On the issue on fraud, if someone on your staff could let us know how much of the fraud in judgment has been classified as uncollectibles.

Secretary THOMPSON. I will get that information. I don't know that off the top of my head, but I will get that information.

Mr. BUYER. Because there are many civil judgments out there that basically you are having to write off. So it sounds like a great number, but if someone no longer has the ability to pay, or they are sitting in jail and they are going to do it in payments over time, I am curious about what that number is.

Secretary THOMPSON. I would be more than happy to get that information to you.

Mr. BUYER. That would be fine.

Second, when I read different articles, and they try—they make these accusations that fraud accounts for approximately 8, 9, 10 percent of the Medicaid program, could you testify as to what it is? What is the number across the spectrum in fraud in the States?

Secretary THOMPSON. I really can't. I can get that.

Mr. BUYER. Could you get——

Secretary THOMPSON. It is pretty hard to measure it, because, you know, people look at it in different ways. But I don't think it is that high, but I don't know if we have ever really quantified it.

I just was handed this. Medicare they said is allegedly around 6 percent. But it could be more than that.

Mr. BUYER. Do you work—do you feel like you have good cooperative—strike that. Do you feel that there is good cooperation between the Federal Government and the States in the area of fraud?

Secretary THOMPSON. Could be better, but I think it is—I think we handled the investigations very well in the Department. Every year we are increasing the amount of money that we are taking in on fraud and abuse claims, and we are getting bigger and bigger judgments.

So our Department works closely with the Department of Justice. We do the investigations. They do the prosecution.

Mr. BUYER. Do you——

Secretary THOMPSON. But I think we have done a good job.

Mr. BUYER. I know that during the 1990's the Clinton administration took a lot of—whether it is the FBI and others—and focused their attention on Medicare/Medicaid fraud. And now we have shifted our focus away from that. Has there been any impact upon your Department with——

Secretary THOMPSON. No. Because our Office of Inspector General continues to do the investigations, and we are doing it—we are very aggressive. In fact, we have expanded our investigations into—we have got offices now in every State in America, which hadn't been done before I came.

Mr. BUYER. Okay.

Secretary THOMPSON. So we are actually being very aggressive. We are also being very aggressive on child support, which is another one of my passions. We have increased the amount of child support collections, which is good for poor mothers and children.

Mr. BUYER. I will be a good listener to your request for greater flexibility to the States for cost efficiencies.

Secretary THOMPSON. Thank you.

Mr. BUYER. And if you could get the answer to me on the uncollectibles on fraud, I would appreciate it.

Secretary THOMPSON. I would be more than happy to, Congressman.

Mr. BUYER. Thank you. I yield back.

Secretary THOMPSON. Thank you for your questions.

Chairman TAUZIN. I thank the gentleman, and the Chair recognizes the gentleman from Louisiana, Mr. John, for 8 minutes.

Mr. JOHN. Thank you, Mr. Chairman.

Also, thank you, Mr. Secretary, for spending several hours with us on issues that are very important. And also, I am very pleased with your commitment to addressing the West Nile Virus. As you are aware, this member, along with a bipartisan group, has passed a bill out of this committee that is waiting in the House to try to address West Nile as it relates to mosquitos and other issues.

Of course, you know, mosquito season is year-round in Louisiana, but it is going to start very aggressive here in the next couple of months. So——

Secretary THOMPSON. I hope you can come over and see my command center, because we attract—we track the West Nile Virus, and we have got it up on a big map, and it is just very revealing.

Mr. JOHN. Well, it is an issue that a couple of years ago may have been unique to Louisiana, because of the mosquito population in Louisiana. But since May of last year when I first introduced the bill, it has become an epidemic across the country, and is no longer just secluded to the States that have mosquitos. So thank you for that commitment on a disease that we need to know a little bit more about.

Also, I commend you on a very difficult task that you have. Medicare reform, Medicaid revamping, prescription drugs, the high cost of the uninsured population, and, of course, just the rising costs of public and private health care. You know, there was a Wall Street Journal article that I was reading the other day that in 2001, it was 14 percent of the GDP.

By 2012, they are predicting that it could be 18 percent of the gross domestic product, which is very significant, and it is an issue

that I think is of utmost importance to the American people. I believe that it has taken a very partisan road up to this point on a vast variety of those issues. But I think the American people want us to address health care in all of the things that I talked about, and we are going to have to get out, roll our sleeves up, and do them.

One of the things that I am concerned about as it relates to my home State of Louisiana is that Louisiana gets today about 70 percent Federal match in its Medicaid dollars, approximately. And that is for every person we cover, regardless of whether it is mandatory or optional.

I am not hung up on words and phrases of block grants or using that as a buzz word. I am just concerned for Louisiana. I would like to know a yes or no answer, because I want flexibility. Unless you can convince me otherwise as we move through this process, I believe that what you are trying to do will provide less flexibility for Louisiana.

And I guess I want a yes or no answer. If my State takes this new option—Louisiana, today we get 70 percent, are we still going to get a 70 percent match——

Secretary THOMPSON. Yes.

Mr. JOHN. [continuing] on that?

Secretary THOMPSON. Yes. Yes.

Mr. JOHN. Will that apply to every single person in Louisiana that is now covered in Louisiana.

Secretary THOMPSON. Under the mandatory population, yes.

Mr. JOHN. But not the optional.

Secretary THOMPSON. That is up to the State and the State legislature. If the State wants to continue it, they will continue getting the same match on the optional population. It is completely discretionary to the State, the same way it is right now. This law doesn't change, Congressman.

The State of Louisiana, and the Governor, could change the law right now and drop all of the optional population and——

Mr. JOHN. Correct. But today they are serving a very—Louisiana has a disproportionate share of the population in the optional, of course, and poor people.

Secretary THOMPSON. But that could—that is completely discretionary with the Governor under the old law. It will be completely discretionary with the Governor and the legislature under the new law, and they will still maintain their 70 percent, Congressman.

The beauty is is that the Governor and the legislature, under the new procedure, will be able to change the mix if they so desire, but still will get 70 percent. And they will——

Mr. JOHN. Seventy percent on the mandatory. So I am just trying to understand. I am trying to overlay this onto Louisiana's scenario. So you would—it would be under the auspices of the legislature and the decision of the legislature whether to provide—continue to provide the optional population as it is today. But you have a population that is receiving benefits today.

Secretary THOMPSON. All right.

Mr. JOHN. If we select your option, then what you are doing is saying that we are going to base it on 2002. And in the own words of your budget it says that the size of each participating State's al-

lotment will be determined by 2002 expenditure levels increased annually using a specified trend rate, not on a population. It is going to be on the—I think you said, what, 9 percent.

But what happens in Louisiana where they get an influx of uninsured or a huge factory closes down, and we have got more uninsured today that are not—or more poorer folks today that would qualify. I mean, today we have that flexibility to move up and down in that optional program and still get to 70 percent.

Under your proposal, the way I understand it, is that we may not have that flexibility, because the legislature will have to cut or readjust or revamp the optional side.

Secretary THOMPSON. No.

Mr. JOHN. Is that not true?

Secretary THOMPSON. That is not true. States will have the option, the same way they have right now, to maintain that optional population and get the 70 percent.

Mr. JOHN. But if I run out of my allotment, because it is a capped—at some point in time——

Secretary THOMPSON. It is not a cap on the mandatory population.

Mr. JOHN. Yes. But I am speaking about the optional. The whole population, mandatory and optional, is what I would like to make sure, because we are providing those services today, and we are getting the 70 percent match.

Under this, I am just concerned that under the optional part, if we run out of the allotment, we won't get the 70 percent match, and we are going to have to either cut the services to these optional folks or do away with them, and, of course, that will have to be up to the legislature to fund 100 percent of it.

So I am not necessarily opposed to what you are trying to do. We have to address the rising costs of Medicare. I just want to make sure that we provide as much flexibility as we can and not—and the way I see it, provide less flexibility in Louisiana if the allotment runs out on the optional side.

So can you help me understand?

Secretary THOMPSON. Let me try. The trend line is what the existing law is. The trend line is 9 percent.

Mr. JOHN. Okay.

Secretary THOMPSON. Okay? It is going to be adjusted. It is adjusted every year. We look out for 10 years. What do we think the trend line is going to be? We do that right now. We thought when we had the 9 percent that is what it was going to be. Next year we have seen that the increases have been higher, so the trend line is going to be 10 percent. The Federal Government puts in that amount of money.

Mr. JOHN. Okay.

Secretary THOMPSON. Okay? Under the current law, and under the future law, if Louisiana takes the choice. Louisiana——

Mr. JOHN. But that is a specified amount of money. Is that not how it happens today?

Secretary THOMPSON. It is an amount of money that is put in that is appropriated each year by Congress. Okay?

Mr. JOHN. Okay.

Secretary THOMPSON. The State of Louisiana can make a choice. Do they want the existing law—they would have that choice, or do they want the new law? The State of Louisiana could maintain the existing law, and they would continue on. They just would not get the increased money up front, the $3.25 billion for the portion that will go to Louisiana.

Mr. JOHN. As the incentive to join one of these programs.

Secretary THOMPSON. The incentive. And it would not, Congressman, get a reduction of payment that the State of Louisiana would have to make to the United States Treasury.

Chairman TAUZIN. The gentleman's time has expired, and the Chair will recognize——

Secretary THOMPSON. So it is completely left up to the State.

Mr. JOHN. Thank you.

Chairman TAUZIN. The gentleman——

Mr. JOHN. I look forward to working with you.

Chairman TAUZIN. Mr. Walden is recognized for 5 minutes.

Mr. WALDEN. Thank you,Mr. Chairman.

I want to get off on a bit of a different topic. I spent 5 years on a nonprofit community hospital board, and, as I watched that operation work, it struck me—and as I meet with physicians and other provider groups, the enormous amount of money that is spent on paperwork.

Secretary THOMPSON. Absolutely.

Mr. WALDEN. Are you looking at some kind of an initiative to help with that? I have thought about we ought to just create some test area out in rural Oregon somewhere, and say you get the same amount of money next year as you got this year, without all of the regs, and let us measure health outcomes and the ability to provide service. Can you help more people with less paperwork? Could you talk to that?

Secretary THOMPSON. I certainly can, and thank you very much for asking me the question.

First off, we set up an advisory committee headed up by Dr. Douglas Wood, a 39-member committee that went around the country and asked, what regulations can we get rid of? They came in, gave me a report last December, a couple of months ago, and with I think 155 suggestions on how we can reduce the paperwork. We have already instituted 31 of those in the area of MTALA, privacy, and so on and so forth—reducing the paperwork.

For one instance on home health, they had to fill out a form that required I think it was 10 pages. We got that down to two pages. And just one example.

The second thing is is that we are trying—we are standardizing the technology standards, so that hospitals and clinics, what the problem has been in the past, hospitals and clinics go out and capitalize and buy new technology as they find out that they can't, you know, interact with their other carriers, their other hospitals. So we are standardizing the thing so we have uniform technology across America that will be much easier to access and work.

The third thing is we are putting in $50 million for demonstration plant in this budget for new technology. And hopefully we will get hospitals in your State of Oregon to be able to look at that and be able to come up with new techniques on how we can use it.

The fourth thing, which I mentioned earlier, and I would like somebody to do it—I would like to take—we get about a billion dollars a year out of fraud and abuse, every year. I would like to take half of that money, $500 million—it has got to be a State legislature—or a State—or a Federal law, but take $500 million out of that, put it into a small fund called the Billy Tauzin Hill Burton Fund. What?

Well, I like that name. But anyway, put it into the fund and take that $500 million, and then allow your hospital from the State of Oregon that wants to capitalize and go into new technology, based upon the new standards, would get $1 for every $3 they invest. And we could change—we could change the delivery of hospitals. We could reduce the paperwork considerably, save costs, and it would be a wonderful, innovative thing. And this committee could lead the way.

Mr. WALDEN. Thank you. I appreciate that.

Let me switch to a different topic, and it is one that I think is on everybody's mind, and that is the threat of bioterrorism.

And one thing I continually hear out in my district is the concern at the very local level, the health clinic level, the county health department level, about the adequacy of resource getting out, especially as we looked at small pox inoculations. And then, the competition between that and other inoculation programs that are in place, and how they do it all.

Can you speak to the administration's proposals relative to that?

Secretary THOMPSON. Absolutely. We are putting in—after this budget, we will have put in $9.3 billion. And this year, we sent out $1 billion to State and local units of government. We asked the State and local units of government to come in by April 15th of this past year with their comprehensive plans, how they would use this State or Federal dollars in order to implement their biodefense, and also how to educate, how to improve communications, how to get their emergency workers better prepared to handle the situation.

We have sent that money out. All the money was sent out by June 1. Not all the States have drawn down the money as fast as I think they should, but they are working on it. We now, in the fiscal year 2003 budget, have got an additional $1.4 billion, and we are putting in $940 million back to the States, $518 million into hospitals' for surge capacities.

We are asking the hospitals first year to have a surge capacity in each region of about 500. This year, it is ratcheted up to 1,000. Next year, it goes to 1,500, in case there is a bioterrorism attack of small pox or botulitim toxins, and so on. And this is all being coordinated by the Department of Health and Human Services out of the Secretary's office and out of the biopreparedness office that I set up, as well as HRSA, FDA, NIH, and CDC.

We will have connected by the end of this year 90 percent of the health departments with a Health Alert Network, which is a communication network by the Department, CDC, FDA, and NIH, so we can send out information every day if need be. We are also going to have now laboratories hooked up to a laboratory capacity network, and we have gone from 88 laboratories to 124, and this year we will be over 240 laboratories.

Chairman TAUZIN. The gentleman's time has expired.

The Chair recognizes Mr. Allen for 5 minutes.

Mr. ALLEN. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for taking some additional time to let those of us in the front row ask questions as well. We appreciate it. I did want to second the comments of Dr. Norwood about the need for standards in your own proposal, the need for standards for insurance companies as they play whatever role you intend them to play.

I have three quick unrelated questions, which I will try to get them all out to you. The first, Healthy Maine Prescriptions is a program that—a vital program in Maine. It is being done through a Medicaid waiver right now. It has been up and running. It provides a reduction in prescription drug costs of about an average of about 20 percent to 112,000 people in Maine.

The program was suspended in Federal court on December 24, pending further action by your Department. The Maine—we are told by the Maine Department of Human Services that your Department may require the State to reduce the eligibility cap from 300 percent of the poverty level to 200 percent of the poverty level, in order to have Healthy Maine Prescriptions reauthorized. That would reduce the potential participants from 225,000 to 38,000.

And I want—the first question is, will you reauthorize that plan? And what would it take to persuade you that 300 percent of the poverty level is a better way to keep people healthy and keep them out of Medicaid? That is one question.

The second question, how would you expect the prescription drug plans to work in Medicare if they are going to be offered through the private insurance market? Particularly in rural States like Maine where Medicare Plus Choice hasn't worked very well, either for beneficiaries or for the companies.

And, third, in relation to the debate that has been going on, many States have constitutional amendments regarding balanced budgets. And as I understand what you are trying to do in Medicaid, over the long run you are basically—what you are doing would stabilize the Federal expenditure on Medicaid to some extent. If that happens, wouldn't it logically lead to more fluctuation in the State level as particular States go through recessions and others don't?

And, you know, you have—recessions don't affect all States equally. There can be a lot of geographic variation. And what I am concerned about is year-to-year variation and people qualifying for Medicaid and then being driven off because the State simply can't afford it.

Those three. Thank you.

Secretary THOMPSON. First off, I have been working—I was working very closely with Angus King before his term expired in Maine. This has been up to many machinations in court, and we are working with Maine right now. But it has been our policy to limit the coverage to 200 percent of poverty, and there has to be a connection to Medicaid. But we are working with the State officials, as we speak, and hopefully we can reach an agreement on it.

The second one in regards to Medicare, how it will work, even in rural Maine, Federal employees, foresters, and people that are

employed by the Federal Government, are covered by the Federal Employees Health Benefit. In the most rural Maine to the most rural areas of Alaska, all Federal employees under the private insurance market have coverage. And so we think the same kind of market would be available for Medicare if we decided to go that way.

The decision has not been made, but you asked me how it worked. It will work the same way that Federal employees in rural Maine now are covered under the Federal Health Insurance Program as they would under Medicare.

Mr. ALLEN. But that is a requirement that is laid down by the Federal Government with respect to the Federal employees, is that right?

Secretary THOMPSON. That is correct. And the same requirement would be laid down for Medicare coverage as well, if, in fact, we went that way. But that decision has not been made, and I want to point that out.

The third thing on Medicaid—let me try and explain this very simply. Medicaid has been around a long time. And Congress has decided certain populations have to have certain minimum requirements. There are mandatory benefits and mandatory populations. That stays the same.

Every year we have to project out what the costs are going to be for Medicaid. We have projected out for 10 years, which is our requirement. We have done that. We have to adjust that every year because more people may come into the system. There may be higher indexing costs of medical expenses. There may be more utilization as the population gets older.

And so what we are saying is that stays the same. That trend line will—is going to remain. We have to recompute that, and it keeps going out for 10 years. But under the procedure, if Maine wanted to do it, Maine would have the opportunity, which it does now under the existing law, to drop optional populations or optional services, we will continue that.

But we would also change the Medicaid law that the State of Maine would be able to devise a health care package for those people that they wanted to cover. For that population, the money would be there. They would get the same match that they currently are. It will be completely voluntary, left up to the Governor and the State legislature.

For that, we are going to advance some dollars, forward funding, $12.7 billion over 7 years. The first year there will be an additional $3.25 billion. I don't know what Maine's share would be, but Maine would get an increase. And that would be the same for 7 years.

And then, the eighth, ninth, and tenth, which would be 2011, 2012, 2013, Maine would still be getting an increase, but their trend line would go below what the rest of the States would be. Their trend line may only be going up at 8 percent instead of 10 percent or 11 percent, but the trend line would be below that for the last 3 years.

But then, the State of Maine would also get another benefit. The other benefit would be is that the State would have to pay less dollars to get this money, because under the current law you have to take into consideration, in order to get the Federal match every

year—Maine does—three things. What the increased population is in Maine; two, what the utilization is; and, three, what the index increase is for medical costs.

We are going to waive the first two—the increased population as well as the utilization. Only the indexing increase of medical costs will the State of Maine have to pay. So that will be a reduction.

That is approximately a billion dollar a year reduction for the States, which equates to almost 1 percentage point increase in the Federal match for this program, so it will continue to get—so Maine will get more money up front, less payment out to get it, more flexibility to develop the program.

The only thing we are asking Maine to do is to split the program. So instead of getting four checks from the Federal Government, one for disproportionate share, one for Medicaid, one for SCHIP, and another check for management, administrative things, they will get two checks—one for acute care and one for long-term care.

And we are asking the State to develop a program for the acute care and the long-term care, so that they will be able to take new innovations that are out there, and we hoping that in Maine they would go to the elderly population and allow the State of Maine to give those individuals the cash to buy the kind of services they want—cash and counseling, which three States have—but also allow the elderly population in Maine to be able to stay in their own home instead of going to the nursing home, to save money and have a higher quality of life in some cases.

And so that is what the Medicaid does. It is not that radical. It really is going to allow States the flexibility to be able to develop a very comprehensive and a very innovative, exciting, new coverage, usually for more population.

Chairman TAUZIN. The gentleman's time has expired.

Mr. ALLEN. Thank you.

Chairman TAUZIN. By the way, I will take a break at this moment and point out, I don't know if you noticed, but the committee ends up under this new rule listening a lot more than talking. I just wanted you all to reflect with me. I think this is working.

Now the Chair recognizes Mr. Rogers for 8 minutes.

Mr. ROGERS. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. I want to just commend you for the work that you are doing. Thank you for taking the leap in the Federal Government. So I want to commend you not only for your work but your bladder control today. Thank you for that. I appreciate it. We have asked——

Secretary THOMPSON. I am going to have to go very quickly.

Mr. ROGERS. I will make it quick, then. We don't want to be responsible for any troubles you may have with that.

I was pleased to see in the 2004 budget the President completing out the doubling of NIH, and that means that roughly 1,500 scientists every year that NIH could hire in addition to where they are at. One thing that you and I chatted about briefly when we were in Michigan was the idea of pain care education and training, something that is woefully neglected in health care today and an incredibly growing problem all across America.

I wanted to get your thoughts on the possibility of support for a national center of pain and palliative care research—regional cen-

ters, so that we can hopefully shove some of these doctors and nurses and anesthesiologists into the notion of adequate pain care understanding for acute care, chronic care, cancer, and HIV pain-related activities. And I was wondering if I can get your thoughts on that, if I may, sir.

Secretary THOMPSON. It happens to be a—it happens to be one of the real growing areas of medical therapy. And I happen to have spoken to their national conferences for the last 2 years, and they are really coming up with some innovative solutions. NIH is working with them, at the Institute on Pain, that the NIH has got some exciting new programs. I am all for it. I think it is going to be very helpful.

And I am still working on getting your 45 pediatric beds to Afghanistan. I haven't forgotten. I——

Mr. ROGERS. Thank you, sir.

Secretary THOMPSON. I have taken it up with the Department of Defense, and I am going to go back to Afghanistan to open up I hope our first maternal child clinic, and I hope to be able to take the 45 pediatric beds with me. And I am giving you credit for it, sir.

Mr. ROGERS. They are ready to go, sir. Thank you very much. I appreciate it.

Secretary THOMPSON. I don't want you to think I forgot.

Mr. ROGERS. No, I know you didn't. And in interest to your bladder, I am going to give back the balance of my time, because I want those beds in Afghanistan, Mr. Secretary.

Chairman TAUZIN. The gentleman yields back the balance of his time, and the Chair recognizes Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you, Mr. Secretary.

I know you are frustrated explaining why this isn't a block grant, and I am going to add to that frustration, I guess, because here is my question.

Secretary THOMPSON. I am not frustrated. I just want you to——

Ms. SCHAKOWSKY. No, I understand. I mean, I feel like maybe I am missing something here, so let me ask what I think is a simple question that may clarify it, at least for me.

Secretary THOMPSON. Okay.

Ms. SCHAKOWSKY. What if Illinois, who—and I agree with Mr. Shimkus' statement that we don't get back as many as—as the Medicaid patients that we have and the amount of money that we spend. But that is another matter, and Illinois needs more money.

But if we run out of money, we opt—we take your option, we run out of money for the mandatory covered people, will the Federal Government provide that money?

Secretary THOMPSON. Yes.

Ms. SCHAKOWSKY. Unlimited. So when you say it is being adjusted up to 10 percent, or whatever, 11 percent, and we go beyond those dollars, no matter what, the money is going to come for those who are under the mandatory program. So there is no cap.

Secretary THOMPSON. No cap.

Ms. SCHAKOWSKY. There is no cap.

Secretary THOMPSON. That is the increase. That is the trend line on the mandatory population. The mandatory population stays the same.

Ms. SCHAKOWSKY. Okay. It is not true, then, that if the money runs out, the State must still cover mandatory people using State money. That is not true.

Secretary THOMPSON. They have to use their State match.

Ms. SCHAKOWSKY. No, the match.

Secretary THOMPSON. But they will get the Federal match, yes.

Ms. SCHAKOWSKY. They will continue to get the Federal match.

Secretary THOMPSON. Same as the existing law.

Ms. SCHAKOWSKY. Okay. Now, this program that you have offered is budget neutral. So, in fact, aren't these dollars really just a loan? It is up front, but in the end don't the States, including those that have not taken the option, have to return the Federal funding through program cuts in later years?

Secretary THOMPSON. No. No, it doesn't. They still will always get an increase, because the trend line keeps going up. That is the difference between a block grant. It is not level funding, Congresswoman. Every year the amount of money going into Medicaid will increase. This year it is going up from $162.4 billion to $176.6 billion, a $14 billion increase.

Next year it will be 10 percent on top of that, so it will be an additional $18 billion——

Ms. SCHAKOWSKY. But it could be—the amount of money that you actually lay out could be significantly higher than that if there are needs in States——

Secretary THOMPSON. But that——

Ms. SCHAKOWSKY. [continuing] to cover more people.

Secretary THOMPSON. The amount of money keeps growing every year. What we are trying to do is we are trying to allow the States the flexibility. The States are also going to get another tremendous benefit because not only will they get advance money that you are talking about, forward-funded $12.7 billion, the States will have to pay less—if they take the option, will pay less to get the Federal match.

It will be a savings of about a billion dollars a year, because, as I indicated, we are only—we are going to waive 2 of the 3 factors that the States will have to pay in. So it is a tremendous deal for the States.

Ms. SCHAKOWSKY. And what happens in 2011?

Secretary THOMPSON. In 2011, they will still get the great deal, because they will pay less money in. But right now, the State of Illinois—I don't know what your Federal match is. About 55 percent?

Ms. SCHAKOWSKY. Fifty.

Secretary THOMPSON. Fifty percent. Okay. So you get 50 percent——

Ms. SCHAKOWSKY. We would love 55 percent from you.

Secretary THOMPSON. You are going to get—if you take the deal, you get 53 percent.

Ms. SCHAKOWSKY. We would like 55 percent.

Secretary THOMPSON. Well, I will——

You have got to settle for 53 percent. Okay? So you go up. If Illinois took the deal, if you kept the same, you would continue on under the existing law and continue getting 9 percent this year, 10 percent next year increases. Under the new voluntary program, the first year you would probably get 13 percent, and then 11 percent, and then 12 percent, and it would go up like this.

When you get out here to 2011, the lines cross. And then, you would still be getting an increase, but instead of getting the 10 percent increase, the State of Illinois would only be getting a 7-percent increase.

Ms. SCHAKOWSKY. The numbers I see starting 11, 12, and 13, are pretty substantial negative numbers.

Secretary THOMPSON. But they are still increases. There is still an increase of 5, 6, and 7 percent.

Ms. SCHAKOWSKY. And we still wouldn't be able to cover the number of people who may need it, if these—if it is negative numbers; that is, relative to the increases we really face.

Secretary THOMPSON. Well, you can—yes, but you can choose. You can choose—you can stay in the existing program if you so desire, Congresswoman, or you can try the new way. I am confident your Governor will take the new way.

Ms. SCHAKOWSKY. Well, because we are in a crisis right now, but it looks like down the road we are going to be in a bigger one.

Chairman TAUZIN. Well, the gentlelady's time has expired. But I think that is an important point that everyone ought to keep in mind. Whatever is being suggested is not a mandatory new program for the States. What you are simply suggesting is a second choice, if the States want to make it, is that correct?

Secretary THOMPSON. That is absolutely correct, Congressman——

Chairman TAUZIN. I thank the gentleman.

Secretary THOMPSON. —Mr. Chairman.

Chairman TAUZIN. Mr. Otter is recognized for 8 minutes.

Mr. OTTER. Well, thank you, and thank you, Mr. Secretary, for being here. I think we only have to go back a few years, although I wasn't in Congress when we went through welfare reform.

Secretary THOMPSON. That is correct.

Mr. OTTER. The tremendous success that we had at your leadership, and all of the nay-sayers that were saying it wasn't going to work, it wasn't going to work. Well, Idaho was one of those States—I was the lieutenant Governor of Idaho then—that had a very high success rate.

Within 3 years we had lowered our welfare rolls by 78 percent. People had a lot more pride in themselves, went back to work. They were getting a paycheck rather than a welfare check, and they appreciated that. And I think that is much of what you are offering us today.

Let me begin by just encouraging you to read most of those written opening statements that were not read, or were not presented to you today. It was much more important, at least as far as I was concerned, to listen to your testimony rather than to provide you with a verbal offering of my written statement.

But there are many things in there that I can—I would like to speak to about the problems that we have with rural health in

Idaho and some of the dislocations as far as the repayment for services that Ms. Wilson from New Mexico talked about.

You can go ahead and call them block grants if you want to with me. I remember that is what we called them with welfare and with some of the other things. That doesn't scare me, because I have a lot of confidence in my Governor. And I have a lot of confidence in my State agencies.

And, more importantly, I have a lot of confidence in the people of Idaho, that when they see that they are going to have a shared responsibility here, that they are actually going to be in control of part of their life. That that is not maybe such a bad idea, because it worked before under your leadership, and, quite frankly, I think that it can work again.

I will tell you this. Many of my constituents paraded through my office after they had seen the President's budget, and said, "We want you to put this back in. We want you to get that back in."

And speaking to Mr. Walden from Oregon's question, I just want you to tell them—I just want you to know what I tell them is I am supporting the President's budget.

Now, if you will come back to me and show me where we can reduce rules and regulations, reporting responsibilities, that will lessen the impact of the money that you do get on your operations and on your administrative costs, I will go to work to try to remove those.

So I was very happy to hear your response to Mr. Walden relative to the fact that you have already got, what, 31, 33 initiatives that you have begun to reduce those costs and to provide the State with a few more options and a few more opportunities to lead themselves.

Let me say, though, the one thing that I find missing in the budget, and maybe that is to come at another time, is I don't see an enlarged responsibility for the individual themselves to take responsibility for their own health care needs or more responsibility for either themselves or for their family.

And I don't know whether we do it through tax incentives or we do it through tax incentives for the entire family, but I would like to see a much larger role played. Now, perhaps there are those that want to take care of everybody cradle to grave, but I don't think that grows the individual. And I think what makes this country great is the growth and the strength of the individual, not necessarily just the collective.

But in a couple of statements that were made to you, relative to the private sector and insurance companies, I want to know, how can we force the insurance company to make—to provide coverage on certain things, without also having a corresponding expectation, a behavioral change.

Let me give you an example—obesity. And that is one that we have talked a lot about, and you have just mentioned what the cost is to the United States.

If there is an illness directly related or aggravated or encouraged by obesity, would we then find that the private insurance company who is now being forced to provide some kind of coverage, would they also be provided—say along with a means test, they would also be provided with an achievement test?

You have lost so much weight, and so you are reducing the aggravation of the obesity. Can we balance this so that the private sector isn't going to be held totally responsible for coverage of people that in some cases may not be wanting to help themselves?

Secretary THOMPSON. You have raised several points, and first let me congratulate you on being lieutenant Governor and working on welfare. And I remember talking with you in Idaho many times, and I think you are going to be an outstanding Congressman.

Mr. OTTER. Thank you.

Secretary THOMPSON. I thank you very much for running.

In regards to TANF versus Medicaid, I think Medicaid is going to be more exciting and more successful than the TANF proposal. I think this new way of Medicaid, and I think once people get comfortable with it I think Governors are going to buy into it, and I think on a bipartisan basis they are going to say, "This is exciting. It is going to be successful."

You asked what thing you can help lead a fight on. There is a big cost factor that we can't get through the Congress, and that is is that we have got to change the contracting of our fiscal intermediaries and our contract carriers.

These are the people that pay the bills for Medicare. There is over a billion transactions annually, and we are restricted on getting fiscal responsibility, and we cannot directly contract out for these individuals. They have to be nominated by State health departments, and so on and so forth.

It would be a huge saving. We have to have 50—right now we have 50 fiscal intermediaries and contract carriers. We could do the job with 10. We could actually do it with four, but we cannot do it because the law prevents us.

In regards to prevention, this is the greatest way in which we can reduce the costs of health care is by getting people to live healthier and eat correctly and exercise. How you set that up—I have been trying to think, coming up with a tax credit for people to lose weight. But how do you actually know that people have lost the weight? I don't know. I don't know how you would be able to enforce that.

But I think insurance companies have got to be encouraged to look at ways to allow for lower health insurance premiums for those people who take better care of themselves. And that is something that you and I can work on. It would be a great achievement, if we could come up with a solution. I don't have the solution yet, but I have been working on it.

Mr. OTTER. Thank you. Thank you, Mr. Secretary.

Thank you, Mr. Chairman. I yield back.

Chairman TAUZIN. I thank the gentleman for yielding back, and the Chair recognizes Ms. Solis for——

Secretary THOMPSON. I really have to get going, Mr. Chairman.

Chairman TAUZIN. I will tell you what I have got. I have Ms. Solis for 5 minutes, Mr. Green for 8, Mr. Stupak is here for 5 minutes. Can you handle that?

Ms. SOLIS. I won't take 5 minutes. I won't take 5 minutes, Mr. Chairman.

Chairman TAUZIN. Can I ask all of you to abbreviate?

Ms. SOLIS. Yes. Actually, I just——

Chairman TAUZIN. The Secretary has been most patient. Ms. Solis is recognized.

Ms. SOLIS. Thank you.

Secretary THOMPSON. I had an appointment at 12:30, and I——

Chairman TAUZIN. I will try to hurry everybody, Mr. Secretary.

Ms. SOLIS. I will be quick. Thank you, Mr. Chairman.

Mr. Secretary, I am going to go off the subject a little here and ask about a program initiative that this administration has been supporting, and that is the abstinence program, the component that is actually offered through your Department, the public health component.

I am wondering if there is any evaluation that has been done on those programs and if you could shed some light on what their performance has been.

Secretary THOMPSON. There is always evaluations. I can get you that information, Congresswoman. I don't have it at the tip of my——

Ms. SOLIS. Okay. That would be great. I would like to see that, because I am very concerned this leads into also where we are looking at prenatal care and for the——

Secretary THOMPSON. Sure.

Ms. SOLIS. [continuing] high teenage pregnancy——

Secretary THOMPSON. I would be more than happy to get it.

Ms. SOLIS. [continuing] that occurs within the——

Secretary THOMPSON. I just didn't think that subject was going to come up, and so I——

Ms. SOLIS. Well, it relates to my district, we have a high number of teenage pregnancies among low income, and especially Latina teenagers, and I am looking to see——

Secretary THOMPSON. I would like to work on an initiative for you.

Ms. SOLIS. Great. Next question is with respect to—I want to applaud the administration also for taking on this issue of chronic diseases, which also is very prevalent in our Latino community. Obesity, asthma, and heart disease——

Secretary THOMPSON. Diabetes is epidemic in the Hispanic communities.

Ms. SOLIS. And I am asking that because I want to know how much moneys are going to be really targeted to your youth media campaign. Last year my understanding is that there was no money provided. This year there is a proposal to expand that. And how do we catch up? I mean, we are far behind now. And is there any mechanism to really go after these groups of individuals that may not speak our language and come from a very different cultural perspective.

Secretary THOMPSON. We do. Just about everything the Department is doing now is in both Spanish and English. And we are doing that with all of our information, all of our messages, all our Medicare announcements. We are doing that, because it is the right thing to do, and it is something that I feel very strongly about.

And we have spent—we had $125 million 2 years ago to set up a program for advertising for youth, and the next year it was $65 million. We didn't use that money because we were in the process

of setting up the program. Now we are rolling that program out. It is called VERB. It is for the tweeners, the ages of 9 to 13.

It is allegedly quite successful. I personally didn't think it was going to be successful, but I am not a tweener. And the tweeners say that they have responded quite nicely to it, and that is what we have to do. But I——

Ms. SOLIS. Can you share that information?

Secretary THOMPSON. I would strongly urge you to work with us, because I am trying to get some new initiatives into the Hispanic communities all over America, as well as the American Indians, because that is where the epidemics are as far as diabetes is concerned.

Ms. SOLIS. And one last question, Mr. Secretary.

Secretary THOMPSON. And the $125 million for prevention is a wonderful new program. I hope you can support it.

Ms. SOLIS. The other question I have is with respect to the National Healthcare Disparities Report that is scheduled to be released at the end of the fiscal year, and I wanted to ask you if you have any updated information about that report.

Secretary THOMPSON. We have updated information. I will get it for you.

Ms. SOLIS. That is a real concern as well with respect to the different communities that we are trying to address here. Thank you very much, Mr. Secretary.

Secretary THOMPSON. Thank you. Thank you.

Ms. SOLIS. Thank you, Mr. Chairman.

Chairman TAUZIN. Thank you, Ms. Solis.

The Chair recognizes Mr. Green for 8 minutes, or less if he will be kind to the Secretary.

Mr. GREEN. Thank you, Mr. Chairman.

I understand, Mr. Secretary, and I appreciate—and the committee does—your time this afternoon. You and I have talked before and come from the State of Texas, and my first question is on the CHIP issue. And I know the chairman and our ranking member have legislation to try and allow the States who didn't expend those CHIP moneys to have 50 percent of them back.

I have a bill that would allow, for example, the State of Texas and other parts of the country who didn't use it—the Office of Management and Budget, if we—if the States lose that money, estimates that there will be 900,000 children who lose CHIP coverage. Is there discussion within the administration about the 50 percent, allowing the States to retain 50 percent? Obviously, I would like 100 percent, because in Texas we lose $285 million for children's coverage.

Secretary THOMPSON. I answer that two ways. Last year we had requested in the budget, which never got passed, all of the unused SCHIP money to go back to the States, not to take anything back into the treasury. This year I think it is a quarter, and you are increasing that to 50 percent.

Mr. GREEN. Yes.

Secretary THOMPSON. We are discussing that, we are looking at it, and I think we are quite supportive of it.

The third thing is under the new Medicaid provision, if the State of Texas would go into it—and I am fairly confident the State of

Texas would, once they get to understand it, that they would be able to use the SCHIP money, the unused money would stay there and they could determine how that money is going to be spent.

Mr. GREEN. Okay. Well, and that brings up—because our Governor gave a State of the State last—yesterday, and he talked about cutting our Texas Medicaid. And if you are familiar with Texas, we are not near as, I would say, rich as Wisconsin in our Medicaid. But cutting it 6 percent—$600 million in State Medicaid, and that includes the $900 million of Federal matching funds——

Secretary THOMPSON. Right.

Mr. GREEN. [continuing] I think, and so it is frustrating to see that happen.

Let me ask a question on the Medicaid and diabetes because, again——

Secretary THOMPSON. I am fairly confident that if the State of Texas—if we had the new Medicaid laws, the State of Texas would not be using—would not be doing that.

Mr. GREEN. Okay. In 1987, you signed a law in Wisconsin that required insurance plans to cover diabetes supplies and services. And you were the first Governor to do that and to sign such a law, and the law was real specific telling insurers also what they need to cover with regard to diabetes.

The good news is that, you know, in Wisconsin, in the States that have followed it, diabetes-related complication is on the decline. And in the case we have seen some comprehensive and prescription laws by—prescriptive laws have been the best to go.

Unfortunately, what we are seeing now in certain States, they are proposing to eliminate some of the diabetes coverage. For example, California is proposing to eliminate coverage for durable medical equipment and diabetes supplies for its Medicaid enrollees. And Oregon is proposing limiting durable medical equipment. Ohio optical services, and different provisions—I know in Texas we are doing some of the same things.

My concern is—and if by the increased effort, for example, on diabetes in select—whether it be expanded populations, African-American, Pacific Islanders, we have a problem, and sometimes related to income. I know the flexibility for our States is good, because I served 20 years in the legislature. But I also know that it is—they could be penny-wise and pound-foolish. And like you said, we need to look at what saves us money in the long run, and, if we can, do some of these things early.

I am concerned that the flexibility will force the States to make some of those tough decisions. If you could share with us just how you would——

Secretary THOMPSON. See, that is what is happening right now, Congressman. States are dropping it. I don't want States to drop these. I think it is more important to give the States the opportunity to restructure the Medicaid budgets so they don't do this.

I think it is a terrible mistake to drop the diabetes thing that I signed into law in 1987. And I was happy to sign it. And we have to do more of these things. It is an epidemic situation in America; 17 million Americans have diabetes, 16 million are pre-diabetic, and we spent $100 billion last year.

And the new Medicaid law would give the State of Texas the flexibility to design their Medicaid provisions, and give them the flexibility, plus the additional money to make sure they wouldn't drop it. I am fairly—see, that is happening under the existing law. That is why we should change it.

Mr. GREEN. Okay. Let me ask one last question, Mr. Chairman, and I will give some time back.

The Medicaid drug rebate—the program——

Secretary THOMPSON. Yes.

Mr. GREEN. [continuing] what exactly is the President's Medicaid drug reform proposal, whether the drug rebate protections will continue to apply to the block grants, so our States can still take advantage of it? And if the protections don't continue to apply, how are we sure that our constituents will be able to get that drug coverage?

Secretary THOMPSON. I would say the—we are going to continue the rebate program. It has worked out very effective.

Mr. GREEN. Well, it seems like in—what I saw contains a discrepancy in the savings achieved from reforming the Medicaid rebate system. The budget indicates your proposal would save $6.4 billion, on page 319. But on page 61, it indicates—the brief indicates it would be $13.2 billion.

What I am concerned about is that rebate proposal has been beneficial to our States for Medicaid. And, again, Texas only provides a very limited amount of Medicaid prescription benefit. But I am worried we would even lose that if we didn't have that rebate provision.

Anyway, you might get back with us.

Mr. Chairman, I am going to—Mr. Secretary, I know it is time—I have got some questions I would like to submit if we could submit them.

Secretary THOMPSON. Give me a call or——

Mr. GREEN. Thank you, sir.

Secretary THOMPSON. [continuing] send me a letter over, Congressman.

Mr. GREEN. I will do it.

Chairman TAUZIN. Yes. And I would encourage all members who have additional questions to consider submitting them in writing. The Secretary has been most patient and his time is out. I still have other members who were not here.

First of all, Mr. Issa passes. I thank him for that.

Now, we have other members who were not here when we opened the session. And I want to recognize you, but I will ask you, please, to be courteous to the Secretary's time. Mr. Pallone?

Mr. PALLONE. Mr. Secretary, I will try to be quick. I wanted to ask one question about dietary supplements and then another one about the Indian Health Service. And, you know, if you can't answer them, you can get back to me later.

Secretary THOMPSON. Sure.

Mr. PALLONE. And I brought these up—the issue of the dietary supplements up last year at this time when you came for a similar hearing. My disappointment basically is with the FDA's responsibility. As you know, Congress intended with DSHEA, the Dietary

Supplement Health and Education Act, to make a clear difference between false, misleading, deceptive claims, and legitimate claims.

And, unfortunately, you know, the FDA hasn't answered the industry's request for guidance in these areas by using its authority to regulate. The most important thing here are the GMPs, the good manufacturing practices.

I had mentioned it last year. They were supposed to be out, you know, last year. They are still not out, and so, first of all, I would like to know whether they are going to come out soon and when. And, second, you know, the FDA has been complaining that they can't do the proper regulation and enforcement, because they don't have enough money. But the budget doesn't seem to reflect a significant amount of money, so that they could make a difference.

Secretary THOMPSON. Congressman, I am not satisfied with the response to you, or to the law. The law was passed in 1994. I mean, it is about time. I am very happy to be able to report to you, because I knew you were going to ask me the question. It is out of the Department. It is in OMB—the rule—and the rule should be out, we think, within days.

Mr. PALLONE. Okay. Well, I appreciate that, and I hope it is days instead of months. But we will see.

Secretary THOMPSON. And hopefully you will like it, and it is a subject that I am interested in, too, as well, and I am looking at it. And I apologize to you.

Mr. PALLONE. No, you don't have to apologize. Let me ask you one——

Secretary THOMPSON. It is out of the Department, but OMB is slow.

Mr. PALLONE. Okay. Now, one of the suggestions that is being made is that within the FDA's Office of the Ombudsman, if we could appoint—and this doesn't require legislation—to appoint a dietary supplement person—in other words, a dietary supplement ombudsman within the Office of the Ombudsman, and, you know, I don't know that that would require additional funding, but I just ask if you would entertain that, to have somebody within the Office of the Ombudsman that specifically deals——

Secretary THOMPSON. Yes, I would.

Mr. PALLONE. Could you follow up on that? Do you think that is a good idea?

Secretary THOMPSON. Yes, I will. And thank you very much for the suggestion.

Mr. PALLONE. Okay. And I know that time is running out, so let me just get to the Indian Health Service.

Chairman TAUZIN. Quickly.

Mr. PALLONE. Is that all right? My concern, Mr. Secretary, is that, again, we are not getting enough funding for the Indian Health Service. In other words, you have a projected increase in the American Indian population of 1.5 percent per year for the next year. You know that the Consumer Price Index for medical care is projected to rise at about 4 percent per year. But the amount of increase in funding for the Indian Health Service is basically about 2 percent.

If you think about the Consumer Price Index as well as the number of the population increase, you would have to figure you prob-

ably need double that. And my question relates to the fact that, of this amount that is in the President's budget, the $3.2 billion, which I think, you know, is inadequate, of this amount $560 million is health insurance collections—in other words, reimbursements for Medicare, Medicaid, and private insurers.

And the majority of these reimbursements, in turn, are for Medicaid. But we know that many States in which the IHS operates are facing severe revenue shortfalls—you have been through this early today—and that they are likely to cut back on Medicaid eligibility benefits and provider payments.

So what I am concerned about is that this budget, which is already, in my opinion, inadequate assumes an increase in health insurance collections, primarily in Medicaid, that aren't going to be there. And I am just, you know, wondering—I don't think it is likely that the Medicaid collections are going to increase. I think they are going to fall off. I mean, do you want to comment on that?

Secretary THOMPSON. Well, first off, I would like to comment. I don't know where you got the figure that it is only up 2 percent. It is—our computation said the Indian Health Service went up $130 million, or an increase of 4 percent.

Mr. PALLONE. Well, I am——

Secretary THOMPSON. I would be more than happy to sit down and go over the figures.

Mr. PALLONE. Yes. We can go off the figures more. But if you could, answer this question about why they are anticipating increases in the third party reimbursement, particularly Medicaid, when we know that right now there has been major cutbacks.

Secretary THOMPSON. All I can tell you, Congressman, is that this is based upon our actuaries and our accountants. They are the ones that come up with these figures. I understand what you are saying. You make a sound argument. I really have no defense of our budget in regards to that, except to say this is what came up through the Indian Health Service, and I am sure it had the impact—input from the actuaries.

Mr. PALLONE. Well, what I will do is if you—with agreement of the chairman, if I can maybe follow up with some questions——

Secretary THOMPSON. Absolutely.

Mr. PALLONE. [continuing] in this regard, because I am concerned that we are going to have a shortfall.

Secretary THOMPSON. Thank you.

Mr. PALLONE. Thank you.

Chairman TAUZIN. The gentleman's time has expired.

Mr. Stupak, if you can make it brief, sir. We have to go to a markup as soon as this hearing is concluded. Mr. Stupak?

Mr. STUPAK. Mr. Chairman, thank you.

Secretary THOMPSON. Does that mean I can go, Mr. Chairman?

Chairman TAUZIN. No, you can't go yet.

Mr. STUPAK. Mr. Secretary, if I may, a quick question or two on the Medicaid block grant flexibility.

Secretary THOMPSON. Yes.

Mr. STUPAK. And the question is really you had a press conference on January 31, and you said something, and I believe you said this. When you have a State—and you know I am from northern Michigan, so I agree with your comments—when you have a

State as diverse and as large as Wisconsin or Michigan, but you went on to say that it is very difficult and very financially costly, almost prohibitive, to provide Medicaid services, but you have to.

Once you start it in one place, which may be good in Milwaukee, but it may be extremely costly in Superior, which is way up in the northern part of the region, it allows States to be able to come up with a program that they could allow for the adjustment in geography.

I guess I am—what do you mean by these comments? Are you implying that if a State found it too burdensome to guarantee people in rural areas access to service under Medicaid, the State would no longer have to do it?

Secretary THOMPSON. Absolutely not, Congressman. In fact, I have stated I think no less than 15 times that the mandatory population is not going to be changed at all. The mandatory benefits are not going to be changed at all. It is only the optional benefits and the optional population that this Medicaid law—proposed law is—and it is completely voluntary, left up to the Governor.

Mr. STUPAK. So the flexibility only comes in on optional programs, not on the mandatory——

Secretary THOMPSON. Optional programs and optional populations.

Mr. STUPAK. Don't have to worry about the kids in northern Michigan not getting treatment because it is too costly up there.

Secretary THOMPSON. No. Absolutely not.

Mr. STUPAK. Okay. I have some other questions. I will put them in writing.

One more, though.

Secretary THOMPSON. Sure.

Mr. STUPAK. In the background we have, you have an additional $13 million for FDA and generic drugs.

Secretary THOMPSON. Yes.

Mr. STUPAK. The drugs out in the marketplace——

Secretary THOMPSON. Yes.

Mr. STUPAK. [continuing] do you have any more money for post-marketing surveillance, so they can find the problems that——

Secretary THOMPSON. I think we put some more money into that, Congressman.

Mr. STUPAK. If you could get back with me on that, it would be interesting to know that.

Secretary THOMPSON. Absolutely. But the $13 million——

Mr. STUPAK. Thank you.

And thank you, Mr. Chairman.

Secretary THOMPSON. [continuing] is put out there so we can get the generic drugs out faster.

Chairman TAUZIN. Thank you, Mr. Stupak.

Unless any other member has a question that they are burning to ask—Mr. Wynn, you have one? Make it quickly, sir.

Mr. WYNN. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here. Thank you particularly for visiting the FDA site for consolidation in White Oak. That is a very important project for all Americans, and we are concerned that that project was zeroed out in the fiscal year 2004 budget.

What we are trying to do with that project is bring 6,000 employees who are now spread out over 39 buildings to one secure location and save the Government $400 million. If you could weigh in to help us get money in this budget, I would appreciate it. Or if we could get that money transferred to your budget, much as CDC is, it would help us——

Secretary THOMPSON. I would like that. I would like that a lot.

Mr. WYNN. Well, if you could talk——

Secretary THOMPSON. If you could help me, I would appreciate that very much, because I was up there and it is—we absolutely have to do it. And I am working on it. I have weighed in on it. I have not been as successful as I would like, and I would appreciate your help.

Mr. WYNN. Thank you. I am happy to do anything that I can. But thank you very much for your efforts.

Secretary THOMPSON. Thank you.

Mr. WYNN. I have no further questions.

Chairman TAUZIN. Thank you, Mr. Wynn.

Mr. Deutsch, you have a quick question?

Mr. DEUTSCH. Right. Just really one question.

Thank you, again, Mr. Secretary. I appreciate it. My staff has been interacting with your staff regarding the issue of drug reimports from Canada. In fact, yesterday there was an interesting article in The Wall Street Journal talking about it, quoting an FDA saying the agency is exercising "enforcement discretion" when it comes to Canadian medication imports.

And, obviously, it is an issue which at this point we really don't have a feel for exactly how many people are availing themselves. It could be, if not in the tens of thousands, even the hundreds of thousands of Americans who are doing that.

What I would ask you is that we actually, in the Oversight Committee, which I serve as the ranking member, we have scheduled a hearing in South Florida which seems to be particularly active in this area, to try to do some investigation from a committee level. And what I would hope is if your staff, you know, can work with us and meet with us, you know, on that so that we can really try together to really get a handle on this and what is the best approach to this issue.

Secretary THOMPSON. I certainly will, and however I can be helpful to further the investigation, I would be more than happy to do so.

Mr. DEUTSCH. I appreciate that. And as I said, I mean, at this point, they have not yet met with us, and that is a standing request. Thank you.

Secretary THOMPSON. Thank you very much.

Chairman TAUZIN. Thank you, Mr. Deutsch.

Mr. Secretary, again, thanks for your extraordinary patience. I hope you consider this a compliment to our committee's interest in the extraordinary work that you do, and we share jurisdiction over, as to the depth and length of the questions today.

My apologies for keeping you as long as we have. But one final thought, I just want everybody in this country who may be tuning in to know how much we all deeply appreciate the fact that this country is safer today and healthier today because of the work you

do, sir. We deeply appreciate and admire your work, sir. Thank you very much.

Secretary THOMPSON. Thank you very much, Congressman. Appreciate that.

Chairman TAUZIN. The hearing stands adjourned.

[Whereupon, at 1:57 p.m., the committee was adjourned.]

[Additional material submitted for the record follows:]

RESPONSES SUBMITTED FOR THE RECORD BY HON. TOMMY G. THOMPSON

QUESTION SUBMITTED BY REPRESENTATIVE NATHAN DEAL

Question: Question regarding SCHIP The Administration's Medicaid Reform Proposal

Response: Mr. Secretary, as I am sure you know, New York has a model S-CHIP program. Nearly 500,000 kids are enrolled and total program costs are approaching $1 billion annually. Yet, the annual federal allotment is just $230 million. Thus, NY is dependent upon redistributed funds to keep the program going.

The President's Medicaid reform policy would lump all Medicaid and S-CHIP money together. As I understand, this is based on 2002 spending. Would this amount be based on the initial S-CHIP allotment or is it based on actual federal spending for S-CHIP taking into account what New York receives in redistributed funds?

Also, under your proposal, would there be redistributions of unused funds for states who are able to expand and cover more children given the appropriate resources? As you know. It is less expensive to insure kids under S-CHIP than it is under Medicaid. With any reforms it is imperative that we do not short-change S-CHIP.

Answer: The Administration's Medicaid Modernization proposal is completely optional for the states. If a state chooses not to participate, then their Medicaid and SCHIP program would remain the same as today. However, if a state did participate in the Medicaid Modernization proposal then the state would not have to worry about insufficient state funds to get its Federal match and risk taking money away from children to pay for other populations' mandatory services. The proposal guarantees funding for mandatory services for mandatory populations. The Administration does not believe that the intent of SCHIP legislation, to provide coverage for uninsured children, would be compromised in any way by the Modernization proposal. Rather, the President believes it is solid reform that will produce efficiencies and enable states to cover even more of the uninsured children. Indeed, the reform proposal builds upon the successes found in SCHIP.

The base allotment for a state would be determined using the state's expenditures for Medicaid and SCHIP for FY 2002. The allotment would be increased annually by an inflation factor. A state would also have access to unspent SCHIP allotments up to the date it elected the optional Modernization plan allotments. The unspent SCHIP allotments would not be increased by an inflation factor.

New York receives more than $230 million per year in allotments as stated in the question. In a recent letter sent to the New York State Medicaid Director, New York was informed of the *interim* redistribution payment amount for approximately $414 million that it will receive for its SCHIP program.

Question: Regarding extending the 340-B provision to inpatient drugs at public hospitals.

Prescription drug coverage clearly needs to be part of the Medicare benefit. While we work to achieve this goal, there are some immediate steps HHS can take to help patients who are particularly vulnerable to prescription drug costs—our nation's poor and uninsured. One step would be to remove a regulatory barrier that is preventing public hospitals such as the New York City Health and Hospital Corporation from accessing lower prices on inpatient pharmaceuticals. Currently, these institutions are paying 20-25 percent more for inpatient drugs than outpatient drugs as a result of the way that CMS interprets the "best price" provision of the Medicaid rebate law.

The VA has agreed to make a change in policy to allow these safety net hospitals to access lower prices but it cannot be effective unless CMS adopts a similar change. CBO has determined that this change would have no impact on the budget including Medicaid. It is my understanding that this change does not require legislation and can be addressed administratively. I am prepared to introduce legislation to clarify this situation but I believe CMS should do this administratively. Is CMS

willing to make this change to help out our nation's safety net hospitals and their patients?

Answer: CMS has not changed its policy at this time. Because of the current State fiscal crises, we are concerned that exempting the purchase of inpatient drugs by 340B hospitals from Medicaid "best price" will cause States to lose funds from drug rebates. We are also concerned that drugs purchased by 340B hospitals will be diverted to other institutions with which the hospital has a relationship. However, we are aware of the important job these institutions perform in serving communities and we are listening to the concerns of these institutions about the impact of the policy on their ability to serve the uninsured.

QUESTION SUBMITTED BY REPRESENTATIVE ELIOT ENGEL

Question: Today this Committee will mark-up the Patient Safety and Quality Improvement Act which, among other things, directs HHS to develop interoperability standards in an effort to reduce medical errors. Medical Informatics technology holds great promise for reducing medical errors. I know that HHS has been working to that end. However I am concerned that neither the bill nor the Administration's budget provides funding to test any standards to ensure their efficacy, usability, and scalability prior to the promulgation of standards.

Mr. Secretary, don't you think that we should test any standards not only to ensure that they work but also to demonstrate to the health care community the benefits of adopting and using these technologies?

Additionally, I fully expected a much larger increase for patient safety initiatives at the Agency for Healthcare Research and Quality (AHRQ). At a time when the Administration and the Majority here in Congress are championing medical malpractice reform I believe we should be doing all we can to prevent medical errors and improve patient safety.

Even with a $29 million increase this year for AHRQ, we are still well below the year 2000 funding level. I intend to dedicate more resources to patient safety issues and hope that you and the other Members of this Committee will work with me to achieve that goal.

Answer: **NOTE:** *Despite two paragraphs on the adequacy of AHRQ's budget, the question does not specifically request a response on this point and the draft answer below doers NOT address that issue.*

Having recently seen the information system used by the Veterans Administration, I believe that the benefits of moving ahead on IT standards are significant. Adoption of integrated information technology (IT) systems is pivotal for public and private sector efforts to improve the quality and safety of patient care, as well as its efficiency and overall effectiveness. Significant progress has been in the past three years toward developing a consensus regarding IT standards and HR 663, which just passed the House of Representatives, calls upon HHS to play a leadership role in making use of these IT standards

At the same time, by studying the early adopters, we can quickly identify implementation issues, and how the private and public sectors can work together to address them. In addition, as we proceed, our staff will determine whether there are aspects of these standards where the benefit of a short-term demonstration to assess efficacy, usability and scalability might be warranted. While the President's FY 2004 budget request does not include funds specifically for such a short-term demonstration, our request for the Agency for Healthcare Research and Quality does include $10 million targeted to overcoming barriers to the use of IT, which could be used if necessary to at least begin such a test.

QUESTION SUBMITTED BY REP. DARRELL ISSA

Question: Will CDC allow the costs associated with smallpox vaccination and follow-up monitoring to be a reimbursable activity for counties and their hospitals? If not, why not?

Answer: As you know, the Congress recently approved a supplemental appropriation of funds that will be provided to States to cover their smallpox vaccination costs. States will soon be notified of the availability of these funds and we are moving quickly to make the grant awards.

Question: Will CDC propose legislation that will provide liability protection and workers compensation coverage for State and local entities that are administering smallpox vaccinations?

Answer: This is an issue that was very important to me, the President, and the Congress. I am happy to say that due to our collective efforts—the Congress, my Department, and the White House working cooperatively on this issue—the Presi-

dent recently signed the smallpox compensation program legislation that the Congress enacted.

Question: Will there be in the near future any special protections against potential cuts in Medicaid for government-operated skilled nursing facilities that are tied to acute care hospitals?

Answer: There are currently no special protections planned regarding potential cuts in Medicaid for government-operated skilled nursing facilities that are tied to acute care hospitals.

Under Medicaid, nursing facility (including skilled level) services are a mandatory Medicaid benefit and therefore all States must provide them regardless if the services are furnished by a free standing facility or hospital based facility.

While States have flexibility to establish the payment rates for nursing facility services, States are required to do so through a public process under which proposed and final rates including the underlying methodology and justifications are published and interested parties are given a reasonable opportunity for review and comment on the proposed rate, methodologies and justifications. We believe that the Congress established this public process because it believed provider payment rates should be established at the local level. Further, the rates must be consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

We strongly encourage these skilled nursing facilities, as well as all providers, to become involved in their state rate setting process.

Question: The current CMS interpretation of the Medicaid Managed Care Regulations seems to indicate that there is a conflict of interest if County Public Health Departments perform enrollment broker services and does not provide an opportunity for rebutting this presumption. This interpretation would prohibit claiming of Federal Financial Participation (FFP) for performing these services in the future. States and local governments interested in performing the enrollment broker function should be permitted to rebut the presumption of conflict of interest. To that end:

a. Was the Congressional intent in these amendments to really prevent any local health department from conducting enrollment broker services?

b. Why is the conflict of interest being interpreted so stringently without a provision to rebut the presumption of conflict of interest by a showing that a public entity is independent?

Answer: The section of the managed care regulations cited, 42 CFR 438.810, follows the language found in section 1903(b)(4)(A) of the Social Security Act. Section 1903(b)(4)(A) of the Act prohibits FFP for amounts expended by a state for the use of an enrollment broker in Medicaid managed care programs unless the broker is independent of "any health care providers (whether or not any such provider participates in the state plan under this title) that provide coverage of services in the same state in which the broker is conducting enrollment activities." Since local health departments would normally be providers of health care services in the same state in which they may be performing Medicaid managed care enrollment activities, we believe the application of this exclusion to local health departments is consistent with the law .

The provision prohibiting FFP for enrollment brokers where there is a conflict of interest is found in section 1903(b)(4)(B) of the Act. This provision prohibits FFP if a person who is the "owner, employee, consultant, or has a contract with the broker" has any direct financial interest with the managed care entity or health care provider.

Both of the statutory prohibitions apply to all entities performing the enrollment broker function on behalf of a state. The statute contains no exceptions for public entities, or authority to deem independent status to an entity under this provision. We believe the regulations accurately reflect the provisions of the statute *and Congressional intent.*

States may use local health departments as enrollment brokers using state-only funds, or may contract with these entities to provide outreach and other non-broker functions and claim FFP for their services. But states cannot claim FFP for enrollment broker services provided by the local health departments.

Question: I am concerned that directing funding to Los Angles to solve their long-standing healthcare problems hurts other counties in the State. San Diego County is sixth largest in the U.S. and has had several hospital closures which puts a tremendous strain on a already precarious healthcare system. What is the level of financial support that we can expect for San Diego, Riverside, and other counties that would help bolster our healthcare infrastructure, especially for the underinsured or uninsured?

Answer: CMS and the State of California consider Los Angeles County (LAC) to be unique and have not found it necessary to provide other counties with special programs similar to those that LAC has received. State and Federal funding provided through the Medicaid hospital disproportionate share program (DSH) and supplemental payments provided through the State's Selective Provider Contracting Program (SPCP) waiver should provide sufficient financial support for other counties in California.

Question: Locally, county clinics and hospitals are seeing increasing numbers of uninsured patients at the same time costs are increasing, nurses are in short supply and reimbursements are decreasing. Does CMS have a strategy or plan to assist local government to provide safety net care?

Answer: The Administration is very concerned about the uninsured and has proposed a variety of initiatives to support clinics in their work. The President's Budget contains a five year initiative to increase the number of patients served by community health centers, helping more than one million additional people receive health care in 2004 through 230 new and expanded sites. The Budget also proposes to increase the number of health professionals to serve underserved areas by providing $23 million in new funding for the National Health Service Corps in FY 2004. The 2004 Budget also proposes to redirect resources from health professions grants for advanced nursing to the Nursing Education Loan Repayment and Scholarship Program, which provides education loan repayments and scholarships to registered nurses in exchange for a commitment to serve in health care facilities with too few nurses, which should assist clinics in recruiting and retaining nurses.

The Administration has also proposed initiatives to reduce the number of uninsured including tax credits for the purchase of health insurance, funding to enable States to start or expand high risk pools to provide coverage, extending for five years the transitional medical assistance program which continues Medicaid coverage for one year those who transition from welfare to work and extending the availability of FY 2000 SCHIP allotments until the end of fiscal year 2004.

QUESTION SUBMITTED BY REPRESENTATIVE EDWARD MARKEY

Question: Massachusetts and other states require immediate and meaningful federal support in order to maintain health care coverage to Medicaid beneficiaries. It is imperative that any federal action to address the current crisis must not put further financial pressure on the states, nor diminish the guarantee of coverage for our most vulnerable patients.

Federal and state governments have an obligation and responsibility to maintain their financial commitment to the Medicaid. However, it is my belief that the Administration's Medicaid Reform proposal would sever the federal and state financial partnership and replace it with a fixed federal commitment and a state maintenance of effort, which begins to unravel the financial foundation of the Medicaid program.

What incentives do states have to expand and improve their Medicaid program when there is a cap on federal matching?

Answer: Because of the federal participation in Medicaid, states have a strong fiscal incentive to expand coverage under Medicaid as much as possible. Yet, 38 states have made program reductions in the past year: 13 cut eligibility; 19 cut services; 8 increased cost sharing; and 23 reduced provider payments. Over 70,000 beneficiaries already have lost coverage, and most states are considering new or additional eligibility or benefit reductions. The reason is that, under the current financing methodology, in order to draw down federal matching funds to expand eligibility, states must be able to increase state Medicaid expenditures as well. The simple reality is that states do not have the state funds needed to take advantage of the federal match to expand coverage. To the contrary, despite the loss of federal funds that will result, tight fiscal constraints are forcing states to cut their programs and reduce coverage.

The Administration's Medicaid modernization proposal will enable states to avoid the cutbacks being made today, and even to expand eligibility, within current budget limits. It is able to do this not only by giving states an infusion of additional federal funds in the first seven years, but by providing states with considerable flexibility to streamline and restructure their programs. This, in turn, will enable states to spend their Medicaid dollars more effectively.

The greater flexibility afforded to states in designing their benefit packages alone will help states to avoid eliminating, and even to expand, coverage. Because they would be able to tailor benefit packages to meet the needs of different populations, states would not be forced to eliminate an optional service for all beneficiaries or an entire optional eligibility group in order to save costs. Conversely, states would be more likely to expand coverage to optional populations, even in tight fiscal times,

because they could offer a more modest benefit package—more in line with coverage in the private insurance market—rather than having to offer new populations all services covered under the state plan.

The response to the Administration's August 2001 HIFA initiative undeniably demonstrates states' interest in expanding coverage to the uninsured, if given the flexibility to make appropriate programmatic reforms, even in these tight fiscal times. Moreover, the ability of states to streamline and simplify their programs under the reform proposal also will generate savings. Under the current funding mechanism, a reduction in state expenditures would result in a corresponding reduction in federal matching funds. Under the modernization proposal, however, the state's federal allotment would not be reduced. Thus, any savings generated by the state under reform could be used to expand coverage.

Question: Families provide 70% of Alzheimer's care and they do this for as long as they can. But because Alzheimer's disease is a chronic disease and most people live with this disease for 8-20 years and health care and medical care is SO expensive, personal assets are exhausted. These patients depend on Medicare and half of these beneficiaries develop symptoms such as dementia and qualify and depend on Medicaid for treatment and care.

The demand will expand exponentially since it is predicted that 16 million baby boomers will develop Alzheimer's. Therefore the demand for long-term care, nursing homes, and Medicaid assistance will expand exponentially as well.

How are we going to establish a health safety net now and for the future with huge tax cuts, inadequate Medicaid support, and giving "flexibility" to the States, which could eliminate nursing home spending?

Answer: Under the Administration's Medicaid modernization proposal, mandatory services for mandatory populations will be protected. This includes elderly individuals who qualify for mandatory coverage, whether or not they suffer from Alzheimer's disease. Nursing home care would continue to be guaranteed for such individuals who require a nursing home level of care and who cannot be cared for in alternative settings. And as I have already stated, protections for nursing home beneficiaries would continue to be enforced. Further, the Administration's proposal continues to provide funding for mandatory services for mandatory populations.

Please keep in mind that the availability of open-ended federal funding has not enabled state Medicaid programs to grow in proportion to the increased need, because states simply do not have the resources to put up their share of the cost. By giving states increased flexibility in designing and administering their programs, the modernization proposal will enable states to avoid cutbacks, and even to expand eligibility without having to increase state expenditures. Any savings generated by the state under the reform proposal could be used to expand coverage—without the state having to appropriate additional state funds. These program savings can be used to then cover a greater number of beneficiaries in more appropriate settings.

Within this broad framework, there are many details which need to be worked out, and we look forward to working with you and other Members of Congress and Governors to develop legislation that balances the flexibility that states need with appropriate beneficiary protections.

Question: Secretary Thompson, as you are aware, the small pox vaccination program has started with a much lower participation than expected and needed. This program's success has been compromised by the Administration's reluctance to create a compensation program for the health care workers who will be injured by the smallpox vaccine. The Administration has included protection for the vaccine manufactures and hospitals but seems to have forgotten the people who could suffer the most the volunteers.

The Institute of Medicine has criticized the vaccine program and has called for better screening, a system for covering lost wages and medical expenses for people who have adverse effects from the small pox vaccine. The unions have recommended that volunteers not participate in this program based on the risk and the lack of compensation for those who will have side effects, not due to negligence.

The administration has wavered about whether you will work with Congress on legislation for a compensation program, Mr. Secretary are you going to work with us to create a sufficient compensation program?

Answer: As you know, this is an issue that was very important to me, the President, and the Congress. I am happy to say that due to our collective efforts—the Congress, my Department, and the White House working cooperatively on this issue—the President recently signed the smallpox compensation program legislation that the Congress enacted.

QUESTION SUBMITTED BY REPRESENTATIVE JOE PITTS

Question: Mr. Secretary, on June 28, 2002 you announced a $14 million project between HHS and the Chinese Ministry of Health. I have a copy of your press release which I will submit for the record.

Mr. Secretary, as I'm sure you are aware, the Chinese Ministry of Health is the entity tasked with enforcing China's one-child policy. All of the forced abortion regulations and orders emanate from the Chinese Ministry of Health.

Just last year, the President revoked money from the UNFPA, in part, because they were working with this coercive abortion regime in China. Mr. Secretary, do you think it is appropriate for HHS to be working with the very agency whose actions our President condemned last year?

Answer: It is the understanding of the U.S. Department of Health and Human Services (HHS) and the Department of State that the Chinese State Family Planning Commission (SFPC), and not the Chinese Ministry of Health (MOH), is the agency of the Chinese Government responsible for all matters relating to the development and enforcement of measures, both voluntary and coercive, to ensure Chinese families adhere to the limits laid out in national and local birth planning laws. The China SFPC drafts, promulgates, and enforces China's national birth planning regulations, which last year the Secretary of State determined to be coercive. Induced abortions are performed at SFPC clinics in support of SFPC birth planning regulations.

According to Chinese law, the MOH has no role in the policy development, communication, regulation, or enforcement of the one-child policy. According to MOH law and regulation, MOH doctors and clinics are not required to report births, pregnancies, or abortions to the SFPC regardless of the "kind" of birth it may be or services they may provide; further they are obliged to provide health care to all children, regardless of registration status and are not required to ask about registration status when a child comes to a clinic. Given this distinction, we believe the MOH is a good and appropriate partner with whom to work on key public health issues, including HIV/AIDS.

After a thorough review of HHS activities in China, we recently discovered that the Centers for Disease Control and Prevention (CDC) has engaged in a limited, staff-level interaction with the SFPC. This interaction apparently began in 2000 and most recently involved the training of an SFPC scientist in clinical trial design for studies related to contraceptive use. We have asked CDC to discontinue this cooperation.

If you have further concerns regarding U.S. policy with China, we would refer you to the U.S. Department of State, with whom we work closely on issues such as this.

Question: As you know, the Advisory Committee on Blood Safety and Availability reports to your office and former Assistant Secretary Eve Slater was the liaison to that Committee. With her recent resignation, what are you doing to assure that the availability and safety of blood and plasma therapies continue to receive the appropriate level of attention?

Answer: I can assure you that the Advisory Committee will continue its work on blood plasma therapies. The departure of Dr. Slater will not have an impact on the agenda or the work of the Committee. In addition, Surgeon General Carmona is now supervising the activities of the Advisory Committee and he is actively involved in blood safety and availability issues. I appreciate your interest in this program.

QUESTION SUBMITTED BY REPRESENTATIVE JOHN SHIMKUS

Question: Historically, states' Medicaid programs have reimbursed hospitals for less than the cost of their care. As a result most of the hospital care provided to Medicaid covered individuals has come from safety net hospitals with missions of serving patients regardless of their ability to pay. Since 1981, we in Congress have required states to make "disproportionate share hospital" (DSH) payment adjustments to hospitals serving disproportionately large numbers of low-income and Medicaid patients. Are the rumors true that the Administration's Medicaid proposal would effectively eliminate the DSH program, which serves our most vulnerable?

Answer: Under the proposal *currently* allowable DSH expenditures would be included in the base year expenditures and those expenditures would be trended forward during the period that the State was in the modernization program. States would have the flexibility to target payments to hospitals and other providers based upon the particular needs in the State.

Question: I understand that under the new proposal states will be given significant flexibility with their Medicaid and SCHIP funding. With all of the new flexibility, how can we ensure where the funds will go (meaning that the funds go to-

ward health care and not highways) and that coverage will not be lost for those in unmandated groups?

Answer: The proposal requires that the Federal allotments be spent only on health care needs of low-income populations under the modernization proposal and these funds cannot be shifted to other programs within the State. Additionally, each State that participates in the proposal will be required to have a maintenance of effort of *current* State funds spending so that they will not be able to use the Federal allotment to supplant State funding to be used for other expenditures in the state.

As for the non-mandatory populations, states *today* have the ability to terminate their coverage. The greater flexibility afforded to states in designing their benefit packages and optional coverage groups under the modernization proposal will actually provide more protection for the optional populations. Thus, because they would be able to tailor benefit packages to meet the needs of different populations, states would not be forced to eliminate an optional service for all beneficiaries or an entire optional eligibility group in order to save costs. Conversely, states would be more likely to expand coverage to optional populations, even in tight fiscal times, because they could offer a more modest benefit package—more in line with coverage in the private insurance market—rather than having to offer new populations all services covered under the state plan.

Question: Right now the state of Illinois receives the lowest federal match allowable by law. While serving 4.5% of the national Medicaid population, Illinois receives only 3.6% of Medicaid funds. How would this reform proposal address this inequality?

Answer: Under current law the Federal government will match all of the Illinois Medicaid expenditures. Under the proposal, states would receive additional Federal funding amounting to $3.25 billion in FY 04 and an additional $12.7 billion over seven years as the Federal trend rates would be higher in the initial seven years of the program. This additional Federal funding, coupled with the increased flexibility to manage its program, would enable States like Illinois to be able *to* address the demands of its Medicaid and SCHIP populations. As long as the state satisfies its maintenance of effort for state spending the state would receive all of its Federal allotment and any unspent Federal allotment would be carried forward from year to year.

Question: I believe that the Medicare program should maintain equity vis a vis benefits, cost, and accessibility among its beneficiaries, who should not be disadvantaged or advantaged merely because of where the live. Rural beneficiaries should have the opportunities to enroll in plans that include outpatient prescription drug benefits comparable to those available to urban beneficiaries. Under your proposal can we ensure that the same basic prescription drug benefit will be available to all beneficiaries and guaranteed in all locations?

Answer: As a former Governor of Wisconsin, I can certainly appreciate the concerns you raise about access for beneficiaries in rural areas. While the Medicare program has provided health security to millions of beneficiaries, it has not kept up with decades of advancement in modern medicine and is facing serious financial challenges.

President Bush has pledged to spend $400 billion over the next 10 years to modernize Medicare and bring more choices and better benefits—including a prescription drug benefit—to Medicare beneficiaries.

Currently, about 76 percent of Medicare beneficiaries have prescription drug coverage either through former employers, Medigap, and other sources. Many beneficiaries are happy with their current coverage, and under the President's plan beneficiaries can keep this coverage. A modernized Enhanced Medicare and Medicare Advantage will be available for those beneficiaries who want more choices and better benefits, including a prescription drug benefit, full coverage of preventive care, and limits on high out-of-pocket costs.

Through enhanced Medicare, all beneficiaries—including those in rural areas—will have choices available to them that will offer better benefits. The types of plans that would participate in enhanced Medicare—most likely preferred provider organizations (PPOs)—are the most popular type of health plan in the market today. PPOs can provide access to care in rural areas from any provider because they reimburse enrollees for care, regardless of whether this care is providing by a "network" provider or not. Under enhanced Medicare, plans will be required to serve an entire region and accept any Medicare-eligible participant; this will minimize risk selection and guarantee access to all beneficiaries.